

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00792

243

1. PLACE OF DEATH:

County Prince George's
 City or town Glen Dale, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month
 Hospital, institution, or street address where death occurred:
Glen Dale Sanatorium
 How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1914 - Belmont Rd. N.W.
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Eleanor Adair

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 26, 1913

8. AGE: Years 32 Months 9 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Wooster, Ohio
 (Town, county, and state)

10. Usual occupation Librarian

11. Industry or business _____

12. Name Robert Lee Adair13. Birthplace Wooster, Ohio14. Maiden name Mary S. Campbell15. Birthplace Glenwood, Indiana16. Informant Decedent

Address _____

17. (Burial, cremation, or removal. Which?)

Date thereof Jan. 20, 1946
(month) (day) (year)

Cemetery or crematory _____

Location Washington, D.C.18. Funeral director The S. H. Jones CoAddress 2901 - 14th St NW

19. (Date rec'd by registrar)

19. Jan. 19, 46 Rowland S. Phillips
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19, 1946 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 20, 1945 to Jan 19, 1946and that I last saw him alive on Jan 19, 1946

Immediate cause of death

Tuberculosis, military

DURATION

1 month

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinucane M.D. M. D. or other _____Address Glen Dale, Md. Date signed 1/19/46

RECEIVED
JAN 29 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlen St., Baltimore

CERTIFICATE OF DEATH

00793

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Bruce George
 City or town Riverdale
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 days
 Hospital, institution, or street address where death occurred:
Beland Memorial Hospital
 How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County D.C.
 City or town D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1116 Nead St. N.E., D.C.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Mary Teresa Allwine

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Martin Lee Allwine
 (deceased) 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Feb. 4, 1896
 8. AGE: Years 69 Months 11 Days 22 If less than one day
 hrs. min.

9. Birthplace D.C. (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Housewife
 FATHER 12. Name Henry Cedeker
 13. Birthplace D.C.
 MOTHER 14. Maiden name Katherine Ryan
 15. Birthplace D.C.

16. Informant John C. Friedrichs (Son)
 Address 3212 8th St. N.E., D.C.
 17. Burial Date thereof Jan 30 - 46
 (Burial, cremation, or removal (Which?) (month) (day) (year))
 Cemetery or crematory Cedar Hill
 Location Bruce George Co
 18. Funeral director The S.H. Thomas Co
 Address 2401-14th St Wash DC
Jan 28 46 James Severy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26, 1946 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1946 to Jan 26 1946
 and that last saw him alive on Jan 25 1946

Immediate cause of death Pulmonary Atelectasis
Generalized arteriosclerosis
Arteriosclerotic heart disease
 Due to Generalized arteriosclerosis
 Due to Arteriosclerotic heart disease
 Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lowland F. Fleckman MDAddress 4404 Greenbury Rd Riverdale D. or otherDate signed 1-27-46

RECEIVED

JAN 29 1946

BUREAU V & E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00794 239

1. PLACE OF DEATH:

County... Prince Georges
 City or town... Rural near Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 2/12/45
 Hospital, institution, or street address where death occurred:
 Laurel Sanatorium
 How long in hospital or institution? Since 2/12/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Prince Georges
 City or town... Rural - Hyde
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Arthur Newton Ambrose

3. (b) Social Security Number

Not Known

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

January 18, 1879

B. (c) If alive, give age _____ years

8. AGE:

67

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Baltimore, Co. Md.
(Town, county, and state)

10. Usual occupation

Farm Work

11. Industry or business

Agriculture

12. Name

John A. Ambrose

13. Birthplace

Maryland

14. Maiden name

Katherine Knowles

15. Birthplace

Maryland

16. Informant

Homer K. Ambrose

Address

1708 Harford Rd, Balto Md

17.

Burial

Date thereof... Feb. 1 - 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Trinity Episcopal

Location

Lanham Md

18. Funeral director

Clarence T. Arthur

Address

208 Balto 2nd

19.

Jan. 30, 1946

(Date rec'd by registrar)

Cora E. Wachter

Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 30, 1946, at 6:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 7, 1945, to January 30, 1946

and that I last saw him alive on January 29, 1946

Immediate cause of death

Congestive Heart Failure

DURATION

2 days

Due to

Chronic Myocarditis

Due to

Senile psychosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Laurel Sanatorium

M. D. or other

Address Laurel Md Date signed 1/30/46

RECEIVED TO THE UNITED STATES DEPARTMENT OF HEALTH

RECEIVED TO THE UNITED STATES DEPARTMENT OF HEALTH

RECEIVED
FEB 2 1946
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

01085

STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Prince Georges

Village or City Seat Pleasant (No. _____) St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Rose Anatta

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>
6 DATE OF BIRTH <u>September 8th</u> , 19 <u>58</u> (Month) (Day) (Year)		
7 AGE <u>87</u> yrs. <u>3</u> mos. <u>3</u> ds. or <u>1</u> day <u>1</u> hrs. <u>1</u> min. <u>?</u>		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>House wife</u> (b) General nature of industry business, or establishment in which employed or (employer) <u>Housekeeping</u>		
9 BIRTHPLACE (State or country) <u>Genoa, Italy</u>		
10 NAME OF FATHER <u>John Jerega</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Italy</u>		
12 MAIDEN NAME OF MOTHER <u>Not known</u>		
13 BIRTHPLACE OF MOTHER (State or Country) <u>Italy</u>		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Teresa M. Killian
(Address) 6820 L Street Seat Pleasant Md.

15 Filed Jan 4 1946 James Severy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
January 3rd, 1946
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 1945 to Jan. 3rd, 1946, that I last saw him alive on Dec 22nd, 1945, and that death occurred on the date stated above, at 10 m. The CAUSE OF DEATH * was as follows:
Chronic Interstitial Nephritis

(Duration) 8 yrs. 8 mos. — ds.

Contributory Secondary Atherosclerosis

(Duration) Not known

(Signed) Arthur H. Meloy M. D.
1-3 1946 (Address) 4400 Bowen Rd DC

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL <u>St. Mary's, Wash. D.C.</u>	DATE OF BURIAL <u>1/5</u> , 19 <u>46</u>
20 UNDERTAKER <u>Wm. J. Talley</u>	ADDRESS <u>3200-R.I. Ave.</u>

If more blanks are needed, address State Registrar, 16 W. Sprutoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

APR 25
BUREAU V. B.

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

CERTIFICATE OF DEATH

01073

Reg. Dist. No. 242

1. PLACE OF DEATH:

County... Clinton Md
 City or town... Prince Georges
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Patrick Joseph Ashe

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Patheine O'Brien Ashe

7. Birth date of

deceased (mo., day, yr.)

Feb 12 1859

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

86

...hrs. ...min.

9. Birthplace

N.Y.C.

(Town, county, and state)

10. Usual occupation

Lawyer

11. Industry or business

FATHER

12. Name

William Ashe

13. Birthplace

Ireland

MOTHER

14. Maiden name

Murphy

15. Birthplace

Ireland

16. Informant

William O'Brien Ashe

Address

Son

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

Jan 25, 1946
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

SA Harris Co

Address

2901 - 14th St. N.W.

19. (Date rec'd by registrar)

19

Thomas D. Buffaloe
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince GeorgesCity or town... Clinton Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan 25 1946, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1946, to Jan 25 1946and that I last saw him alive on Jan 23 1946

Immediate cause of death

Rt. Bronchopneumonia, 10 days

DURATION

Due to

Due to

Other conditions

CardiovascularRenal Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. none

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William O'Brien Ashe
M. D. or other

Address

Washington 98 Date signed 1.25.46

RECEIVED

MAR 18 1946

BUREAU V S

Evidence for change of year
of birth of deceased is
shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B7a)

00795

245

FILM No. I 00 FEB 1 1946

CERTIFICATE OF DEATH

★ Reg. Dist. No. 245

1. PLACE OF DEATH:

County 3308-40th Pl Pr. Sec
City or town Calman Manor
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

80mo

How long in hospital or institution?

3. (a) FULL NAME

EMMA LOUISE BANE

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

Chas C. Bonf.

7. Birth date of
deceased (mo., day, yr.)

Nov. 10 - 1860 1861

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

84

hrs.

min.

9. Birthplace

Washington DC

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

August Herfurth

13. Birthplace

Germany

14. Maiden name

Amelia Ponzel

15. Birthplace

Germany

16. Informant

Maude E. Dean

Address

3308-40th Pl

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 19 46
(month) (day) (year)

Cemetery or crematory

W.

Location

St. S. A. / Times Co

18. Funeral director

Address

2901-14th St NW

19.

Date rec'd by registrar

January 19, 46 James Severs

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

5125-7th St NW
(If outside city or town limits, write RURAL and give nearest town)

Street No.

Wash DC

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 19

1946

at

7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/19 1946 to 1/19 1946
and that I last saw h. cr. alive on 1/19 1946

Immediate cause of death Arterio-sclerotic
Heart & Kidney disease
Senility

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

3717-38th Ave

Date signed

1/19/46

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 22 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01074

CERTIFICATE OF DEATH

Reg. Dist. No. 243

FILM No. 101 MAR 26 1946

1. PLACE OF DEATH:

County Prince Georges
City or town Fairmount Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
719-58 Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges
City or town Fairmount Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No. 719-58 Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Agnes E. Banks

3.(b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife George Banks

7. Birth date of deceased (mo., day, yr.) April 15 1864 8.(c) If alive, give age years

8. AGE: Years 81 Months 8-2 Days 8-2 If less than one day hrs. min.

9. Birthplace Louisiana County, Va.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business own home

12. Name John Johnson

13. Birthplace Louisiana Co., Va.

14. Maiden name Emily Johnson

15. Birthplace Louisiana Co., Va.

16. Informant Mrs. Eva B. B. B.

Address 719-58 Ave

17. Date thereof 1/7/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Removal

Location

16. Funeral director Thurman B. Mantgomery

Address 913 Fla. Ave NW

19. 1-7 19 46 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1946 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Jan 7 1946
and that I last saw her alive on Jan 7 1946

Immediate cause of death Cerebral Hemorrhage DURATION 1 day

Due to Hypertension

Due to Hypertensive Cardiac Vascular Disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. E. Beeson M. D. or other

Address 423 Hunt Pl. NE Date signed 1-7-46

REC-117
MAR 18 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B4

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County... Prince Georges
 City or town... (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr., 9 mos., 26 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution? 1 yr., 9 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... D. C. County...
 City or town... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 2725 Sherman Ave., N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... ✓

3. (a) FULL NAME

BLACKFORD, GOLDIE

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife...
 7. Birth date of deceased (mo., day, yr.) April 5, 1929 6. (c) If alive, give age... years
 8. AGE: Years 16 Months 9 Days 8 If less than one day hrs. min.

9. Birthplace Washington, D. C.
 (Town, county, and state)
 10. Usual occupation Student
 11. Industry or business
 12. Name Howard N. Blackford
 13. Birthplace Washington, D. C.
 14. Maiden name Estelle Coram
 15. Birthplace Washington, D. C.

16. Informant Decedent
 Address
 17. Removal Date thereof Jan 14, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Washington
 Location D. C.
 18. Funeral director W. Ernest Jarvis Co
 Address 1432 8th St. N.W.
 19. Jan. 13 46 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1946 at 9:56 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 Mar 18 1944 to Jan 13 1946
 and that I last saw her alive on Jan 13 1946
 Immediate cause of death Pulmonary Tuberculosis
 DURATION 21 mo 27 da
 Due to Genit. Urinary Tuberculosis 11 M.D.
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op...
 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pincane M.D.
 M. D. or other
 Address Glenn Dale Md Date signed 1/13/46

RECEIVED
JAN 19 1946
BUREAU V.S.

RECEIVED
JAN 19 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

00797



Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George

City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months

Hospital, institution, or street address where death occurred:

David Hunt Home

How long in hospital or institution? 11 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg

City or town Chess Creek 15
(If outside city or town limits, write RURAL and give nearest town)Street No. 6306 Delaware St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Thomas Francis Gray

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

73

Years

6

Months

26

Days

If less than one day

hrs.

min.

9. Birthplace

Bridgeport Conn

(Town, county, and state)

10. Usual occupation

Bookbinder

11. Industry or business

12. Name

Patrick Gray

13. Birthplace

Bridgeport Conn

14. Maiden name

Julia Leavy

15. Birthplace

Bridgeport Conn

16. Informant

Mrs Wm Gray

Address

6306 Delaware St. Chk 15

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

January 18, 1946

(month) (day) (year)

Cemetery or crematory

St. Michael's Cemetery

Location

Bridgeport Conn.

18. Funeral director

James F. Ryan, Inc.

Address

317 Pa. Ave. S.E.

19. Jan 18

(Date rec'd by registrar)

19. 46

James Beever

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 46, at 3:38 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 40, 19, to Jan 18, 1946

and that I last saw him alive on Jan 17, 1946

Immediate cause of death

Congestive Heart Failure

Due to

Atherosclerosis

Due to

DURATION

10 days
by rx +

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James F. O'Donnell

Address 4302 E W Hymen Belknap 4 M. D. or

Date signed 1/18/46

CERTIFICATE OF DEATH

RECEIVED

JAN 24 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (312)

CERTIFICATE OF DEATH

Reg. Dist. No. 00798 234

1. PLACE OF DEATH:

County Prince George's

City or town Melrose

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hours

Hospital, institution, or street address where death occurred:

Blythe Wood Farms

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Shelwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Kenneth Owen Brown

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

B. (b) Name of husband or wife

Cora Brown

7. Birth date of deceased (mo., day, yr.)

Feb 28, 1873

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

72 10 16 hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Farm

12. Name

Kenneth Brown

13. Birthplace

Baltimore

14. Maiden name

Elizabeth Zell

15. Birthplace

Ireland

16. Informant

Edith Langford

Address

Upper Marlboro, Md

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof Jan 17-1946

(month) (day) (year)

Cemetery or crematory

Ledar Hill Cemetery

Location

Suitland, Maryland

18. Funeral director

Thomas F. Murray

Address

2007-Nichols Ave SE

19. Jan 14 1946

(Date rec'd by registrar)

19. 46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1946 at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., 10....., 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Acute congestive heart failure

Due to

Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

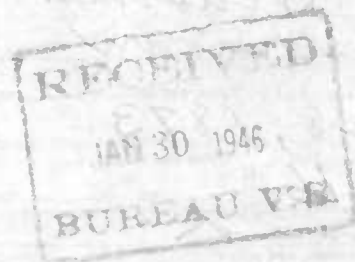
Injured at work

Reported medical condition

23. SIGNATURE James J. Ford

M. D. or other

Address Forestville Date signed 1-14-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

CERTIFICATE OF DEATH

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County... Prince George's
 City or town... (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr., 11 mos.
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution? 1 yr., 11 months.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D. C. County...
 City or town... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 317 Virginia Ave. S. E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war... - ✓

3. (a) FULL NAME

THOMAS F. BROWN

3. (b) Social Security Number

Lost

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Myrtle Brown (dec.)

7. Birth date of deceased (mo., day, yr.)

May 29, 1908

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

37

8

-

hrs. min.

9. Birthplace

Washington, D. C.

(Town, county, and state)

10. Usual occupation

Odd jobs.

11. Industry or business

FATHER

12. Name

Robert Brown

13. Birthplace

Maryland

MOTHER

14. Maiden name

Mary Manokey

15. Birthplace

Maryland

16. Informant

Decedent

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Removal Jan. 29, 1946

(month) (day) (year)

Cemetery or crematory

Payne Cemetery

Location

D.C.

18. Funeral director

W. Earl Better

Address

1203 Walter St. S. E.

19.

(Date rec'd by registrar)

Jan. 29, 46 Rowland S. Phillips

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1946 at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 29

19 44

to Jan 29

19 46

and that I last saw him alive on Jan 29, 1946

Immediate cause of death

pulmonary tuberculosis

DURATION

1 1/2 yrs. - 1 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Pinetane MD

M. D. or other

Address

Glenn Dale, Md

Date signed 1/29/46

RECEIVED
FEB 5 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year
of birth of deceased is
shown on
FILM No. I 00 JAN 18 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Prince George's Gen. Hosp.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Prince George
City or town College Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6902 Carlton Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Bunting, Miss Elsie Jean

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 24 1890 1889 6.(c) If alive, give age... years

8. AGE: Years 56 Months 7 Days 3 If less than one day... hrs. ... min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation School Teacher, Clerk

11. Industry or business U.S. Treasury Dept. Work, D.C.

12. Name Harry Bunting

13. Birthplace Maryland

14. Maiden name Adelaide Harris

15. Birthplace Virginia

16. Informant Aurand, Miss Margaret

Address 6902 Carlton Terrace, College Park, Md.

17. Burial Date thereof Jan 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethel Cemetery

Location Alexandria Va

18. Funeral director F. Guiche, sons

Address Hyattsville Md

19. 1/6 46 Manda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 19 46 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-19 to 9-16 19 45 to 1-3 19 46

and that I last saw him alive on 1-2 19 46

Immediate cause of death Anteriorly

Coronary Heart Disease DURATION 1 year

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE W.B. Murray, M.D. M. D. or other

Address Int. Racine, Ind. Date signed 1-3-46

STATE OF TEXAS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JAN 9 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:

County Prince GeorgesCity or town Chesley, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 1/2 days

Hospital, institution, or street address where death occurred:

Prince Georges Hosp.How long in hospital or institution? 2 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince GeorgeCity or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Burroughs, Mrs. Minnie

3. (b) Social Security Number

4. Sex

7

5. Color or race

w

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

George I. Burroughs

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

July 13, 1868

8. AGE:

Years

Months

Days

It less than one day

77

hrs.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER
MOTHER

12. Name

Frank Deuell

13. Birthplace

Md.

14. Maiden name

Rebecca Lasser

15. Birthplace

Md.

16. Informant _____

Address _____

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

1 16 46
(month) (day) (year)

Cemetery or crematory

St. Thomas

Location

Exroom Rd

18. Funeral director

Ritchie Bros

Address

Upper Marlboro Md19. 1/16

(Date rec'd by registrar)

19. 46Amanda Deaney

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 19 46 at 9:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 19 46 to Jan 16 19 46and that I last saw him/her alive on Jan 16 19 46

Immediate cause of death

Constrictive Heart Failure
Myocarditis

Due to _____

Due to _____

Other conditions

Atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op. _____

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James P. Lasser

Address

Upper Marlboro Md

Date signed

1-16-46

MAINE AND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JAN 18 1946

BUREAU V.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 467

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George
 City or town Riverdale
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Two weeks
 Hospital, institution, or street address where death occurred
Selander Memorial Hospital
 How long in hospital or institution? Two weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George
 City or town Riverdale
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4408 Greenbury Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Mr. John Coles Clay

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Lucy Elizabeth Clay

7. Birth date of deceased (mo., day, yr.) July 12, 1872
 8. AGE: Years 73 Months 6 Days 14 If less than one day
hrs.min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation Retired

11. Industry or business

12. Name John William Clay
 13. Birthplace Virginia
 14. Maiden name Catherine Thompson Payne
 15. Birthplace Virginia

16. Informant wife
 Address Rosemary Lane, Hyattsville Md.

17. Transportation auto Date thereof Jan 28, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory altavista ra
 Location altavista ra

18. Funeral director F. Buschi some
 Address Hyattsville Md.

19. Jan 27 46 James Severy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Jan 26 19 46 at 6:02 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 26 19 46 to Jan 26 19 46
 and that I last saw him alive on Jan 26 19 46

Immediate cause of death Carcinoma of Stomach DURATION 6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations no surgery Date of op.

Autopsy results not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. W. Malin M.D. M. D. or other

Address Riverdale Md. Date signed Jan 26, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED

JAN 29 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1360

CERTIFICATE OF DEATH

00803

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince GeorgeCity or town Bowie
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Bowie
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

James Cornwell

3.(b) Social Security Number

4. Sex

male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of
deceased (mo., day, yr.)1902

8. AGE:

44

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Columbia, S.C.
(Town, county, and state)

10. Usual occupation

Groom

11. Industry or business

Horse Racing

MOTHER

12. Name

William Cornwell

13. Birthplace

South Carolina

14. Maiden name

Lucinda Gladness

15. Birthplace

South Carolina

16. Informant

Willie Green

Address

Bowie, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 28 46
(month) (day) (year)

Cemetery or crematory

Brooklyn Glades

Location

P. 3rd Cr.

18. Funeral director

Martin Flodung Lars

Address

Bowie Md.

19.

(Date rec'd by registrar)

19

James W. Gungling
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1946, at 3:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h..... alive on

19

Immediate cause of death

Coronary heart
failure

Due to

Cardiovascular

Due to

renal disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

helping medical examiner

23. SIGNATURE

James W. Gungling

M. D. or other

Address

1121 W. 1st St.

Date signed

1-26-46

RECEIVED

JAN 29 1946

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

Reg. Dist. No. 00801 245

1. PLACE OF DEATH:

County..... Prince George
 City or town..... Riverdale Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 days
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?..... 3 days

3. (a) FULL NAME

Edward A. Cooper

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

Male White

6. (b) Name of husband or wife..... 6. (c) If alive, give age.....

Clair Mae Cooper 61 years

7. Birth date of deceased (mo., day, yr.).....

Aug. 2, 1888

8. AGE: Years..... Months..... Days..... It less than one day.....

5755hrs.min.

9. Birthplace.....

Virginia
(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business.....

Retired

12. Name.....

Joseph Alexander Cooper

13. Birthplace.....

Va.

14. Maiden name.....

Dorothy Fisher

15. Birthplace.....

Virginia

16. Informant.....

Bernhard Dell Cooper (son)

Address.....

5111 P St. S.E., D.C.

17. Burial..... Date thereof.....

(Burial, cremation, or removal. Which?)

January 9, 1946
(month) (day) (year)

Cemetery or crematory.....

Cedar Hill Cemetery

Location.....

Bethesda, Md.

18. Funeral director.....

J. H. Hines Co.

Address.....

2901 - 14 St. N.W., Wash. D.C.

19. Jan. 7, 1946..... 19. 46.....

(Date rec'd by registrar)

James Sever

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5200 P St. S.E., D.C.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19. 46 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 20 19. 45 to Jan 7 19. 46and that I last saw him alive on Jan 7 19. 46

Immediate cause of death.....

Cerebral

Due to.....

Hyper tension

Due to.....

Phosphorus

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results..... Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... M. D. or other

Edward L. Moore 18 Carroll Ave 1946

Address..... Date signed.....

RECEIVED

JAN 11 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01.805 245

FILM No. 100 FEB 14 1946

1. PLACE OF DEATH:

County Prince George's County

City or town Riversdale, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? seven days

Hospital, institution, or street address where death occurred:
Selander Memorial Hospital

How long in hospital or institution? seven days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn. County Philadelphia County

City or town Philadelphia
(If outside city or town limits, write RURAL and give nearest town)

Street No. 947 South Third Street
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME

Ms. Rebecca Coplin

3. (b) Social Security Number

4. Sex female

5. Color or race white

6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife Mr. Joseph Coplin

6.(c) If alive, give age 70? years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1878

8. AGE: Years 67 Months 68 Days 0 If less than one day 25 hrs. — min. —

9. Birthplace Karno, Lithuania
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Jacob Weiner

13. Birthplace Russia

14. Maiden name Sarah? Weiner

15. Birthplace Russia

16. Informant Michael Coplin

Address 427 Hamilton Street N.W. Wash

17. Burial Date thereof Jan 10 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Har Noto Cemetery

Location Phila Pa

18. Funeral director B. D. Dwyer & Son

Address 3501-14th St N.W. Wash

19. Jan 10 19 46 James Devoy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 19 46, at 7:21 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on — 19 —, to — 19 —

Immediate cause of death

congestive heart failure
Crushed chest

Due to

Other conditions

Advanced Cardiovascular renal disease
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 1-2-46

Where did injury occur? Beltville P. S. Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Road

Means of injury Passenger in auto Injured at work? no

23. SIGNATURE Dr. Forestall M. D. or other

Address Forestall Date signed 1-10-46

PLEASE DO NOT WRITE IN THESE SPACES

RECEIVED

RECEIVED
JAN 14 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 473

CERTIFICATE OF DEATH

00806

Reg. Dist. No.

231

1. PLACE OF DEATH:

County Prince Georges
 City or town Chenery
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 days
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

9 days

3. (a) FULL NAME

Cordes, Mrs. Annie

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Adolph

7. Birth date of deceased (mo., day, yr.)

Jan. 15 - 1864

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

81

hrs.

min.

9. Birthplace

Nova Scotia
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

August Jannet

13. Birthplace

France

MOTHER

14. Maiden name

Catharine Keating

15. Birthplace

Nova Scotia

16. Informant

Address

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

1-9-46
(month) (day) (year)

Cemetery or crematory

Amundale Cemetery

Location

Amundale, Md.

18. Funeral director

Widchambers

Address

Amundale, Md.

19.

Jan. 7 1946
(Date rec'd by registrar)Amanda Downey
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED;

(For newborn infants give residence of mother)

State

Md.

County

Prince George Co.

City or town

Greenbelt
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION 46

20. DATE OF DEATH

1-519 46

at

4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 2819 46

to

Jan 519 46

and that I last saw him alive on

Jan 319 46

Immediate cause of death

Toxemia

DURATION

Due to

adenocarcinoma

Due to

ovary

Other conditions

Patrol antitubercular
observed
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. M. Jannet

M. D. or other

Address

Prince Georges
Post Office

Date signed

1-5-46

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JAN 10 1946
BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No.

00807 239

1. PLACE OF DEATH: County... <u>PRINCE GEORGE</u> City or town... <u>LAUREL MD</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>47 YRS</u> Hospital, institution, or street address where death occurred: <u>WARREN HOSPITAL</u> How long in hospital or institution? <u>2 1/2 DA.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>MD</u> County... <u>Prince George</u> City or town... <u>Laurel</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Montgomery Ave</u> (If rural, give LOCATION) 2. (a) If veteran, name war...			
3. (a) FULL NAME <u>MINNIE MITCHELL DONALDSON</u>				3. (b) Social Security Number			
4. Sex <u>FEMALE</u> 5. Color or race <u>WHITE</u> 6. (a) Single, married, widowed, or divorced <u>MARRIED</u>				MEDICAL CERTIFICATION			
6. (b) Name of husband or wife <u>DEWILTON H. DONALDSON</u> 7. Birth date of deceased (mo., day, yr.) <u>MAR 24 1877</u> 8. (c) If alive, give age <u>69</u> years				20. DATE OF DEATH <u>1 1 1946</u> at <u>6 A</u> M 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from <u>1 2 10 1945</u> to <u>1 1 1946</u> and that I last saw her alive on <u>1 1 1946</u> Immediate cause of death <u>Pneumonia</u> DURATION <u>4 d</u>			
8. AGE: Years <u>66</u> Months Days <u>6</u> hrs. min.				9. Birthplace <u>PRINCE GEORGE CO</u> (Town, county, and state)			
10. Usual occupation <u>HOUSEWIFE</u>				11. Industry or business			
12. Name <u>FRANKLIN P. MITCHELL</u>				13. Birthplace <u>Prince George Co Md</u>			
14. Maiden name <u>Marion Caldwell Aitchison</u>				15. Birthplace <u>Prince George Md</u>			
16. Informant <u>Marion D. Flewamb</u> Address <u>SMYRNA DEL</u>				17. Burial <u>1-3-46</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Joy Niece</u> Location <u>Laurel Md</u> 18. Funeral director <u>The H. C. White Co.</u> Address <u>Laurel Md</u>			
19. January 3 46 (Date rec'd by registrar)				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide... Date of... Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?			
23. SIGNATURE <u>J. B. P. Warner</u> M. D. or other Address... Date signed...				24. Signature <u>Co. E. Wadley</u> Deputy Registrar			

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JAN 14 1946
BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Frederick Georgia
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
State MD County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. Montgomery Rd
(If rural, give LOCATION)
2. (a) If veteran, name war:

3. (a) FULL NAME

Lewis P. Dowling

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Jennie Dowling

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 4 - 1864

8. AGE: Years 81 Months 8 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Frederick, N.D. (anddy)
(Town, county, and state)

10. Usual occupation Chemist

11. Industry or business Paper mill

12. Name Shos. Dowling

13. Birthplace Canada

14. Maiden name Mary Ann Fillmore

15. Birthplace England

16. Informant Mrs. Wm. J. Sharp

Address Frederick, Md.

17. Burial Date thereof Jan 31, 1946
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. George's

Location Frederick, Md.

18. Funeral director West Hill Funeral Home

Address Frederick, Md.

19. Jan 30 1946 M. Piaskeare
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25 8-6 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-24 1946, to 1-25 1946

and that I last saw him alive on _____ 19____

Immediate cause of death Acute Cardiac Dil DURATION 1 day

Due to Bronchopneumonia 4 d.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE B. P. Piaskeare M. D. or other _____

Address Frederick, Md. Date signed Jan 30 - 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 1 1946
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 936

CERTIFICATE OF DEATH

00869

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince GeorgeCity or town Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 354 daysHospital, institution, or street address where death occurred Leland Memorial HospitalHow long in hospital or institution? 354 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County D.C.City or town D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 1225 Decatur St. Washington
(If rural, give LOCATION) D.C.

2.(a) If veteran, name war

3. (a) FULL NAME

Joseph William Duvel

3. (b) Social Security Number

4. Sex M. 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Elva Smith Duvel7. Birth date of deceased (mo., day, yr.) 11-16-18738. AGE: Years 72 Months 1 Days 23 If less than one day 66 years
hrs. min.9. Birthplace Quincy Co. Ohio
(Town, county, and state)10. Usual occupation Chief of Commodity Exchange11. Industry or business Retired12. Name August Duvel13. Birthplace Ohio14. Maiden name Amanda Myers15. Birthplace Ohio16. Informant Hospital RecordsAddress Riverdale, Md.17. Cremation Date thereof Jan. 10, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Society or crematory St. Louis CemeteryLocation Colman Manor, Md.18. Funeral director The S. H. Hines Co.Address 2901 14th St. N.W. - D.C.19. 1/8/46 19. 46 James Severy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1946 at M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 to Jan 8 19. 46and that I last saw him alive on Jan 7 19. 46Immediate cause of death Chronic heart disease DURATION years
with hypertensionDue to Cerebral hemorrhage 1 yrDue to Myocardial infarction & general weaknessOther conditions He has been vegetative for 6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations 0Date of op. 0Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; 0Accident, suicide, or homicide 0 Date of 0

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Chas. H. Holbrook MDAddress 500 Underwood Rd. N.W. - D.C.23. SIGNATURE 500 Underwood Rd. N.W. - D.C.Date signed 1/8/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 11 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-20

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County PRINCE GEORGECity or town FORESTVILLE
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LIFE

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County PRINCE GEORGECity or town FORESTVILLE
(If outside city or town limits, write RURAL and give nearest town)Street No. 7530 MARLBORO PINE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

WILLIAM. HENRY EMORY JR

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) JULY 9/37 6.(c) If alive, give age years8. AGE: Years 8 Months Days If less than one day
hrs. min.9. Birthplace WASH DC
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name WILLIAM. H. EMORY13. Birthplace BALTO MD.MOTHER 14. Maiden name NETTIE PORTER15. Birthplace BALTO MD16. Informant WILLIAM. H. EMORYAddress 7530 MARLBORO PINE MD17. BURIAL Date thereof 11/12/46
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory CEDAR HILLLocation SOUTHARD MD18. Funeral director St. J. Chambers & CoAddress 317 N. 2nd St19. June 11 19 45 Wmpos D. Syphers
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 19 46 at 5:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 9 19 46 to Jan 10 19 46 and that I last saw him alive on Jan 19 19 46Immediate cause of death Cerebral thrombosis
Paralysis Left SideDue to Epilepsy

Due to

Other conditions Mal developed
mentally and Physically
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Wmpos D. Syphers M. D. or D. O.Address Washington 19 DC Date signed Jan 10/46

RL

MAR 18 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1642

CERTIFICATE OF DEATH

Reg. Dist. No. 248

1. PLACE OF DEATH:

County Prince Georges
 City or town Chillum
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month
 Hospital, institution, or street address where death occurred:
716 - Chillum Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Chillum
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 716 - Chillum Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War II

3. (a) FULL NAME

John Henry Fitzgerald

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mrs. Ardella Fitzgerald
 6. (c) If alive, give age 24 years
 7. Birth date of deceased (mo., day, yr.) February 24, 1911
 8. AGE: Years 34 Months 11 Days 3 If less than one day hrs. min.

9. Birthplace Virginia
 (Town, county, and state)

10. Usual occupation Plasterer

11. Industry or business Builder

12. Name John S. Fitzgerald

13. Birthplace Virginia

14. Maiden name John C. Fitzgerald

15. Birthplace Virginia

16. Informant Margaret Chapman

Address 716 - Chillum Road

17. Burial Date thereof Jan 30, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Colman Manor Md

18. Funeral director F. Gasche, son

Address Hyattsville Md.

Jan 30 1946 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1946 at 3:46 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Thrombophlebitis and shock

Due to gun shot wound

Due to of head

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 1-27-46

Where did injury occur? Chillum (City or town) P.T. (County) has (State)

Injured at home, farm, industry, public place (where?) home

Means of injury shot Injured at work? no

Reputed Medical Examiner

23. SIGNATURE James Sever M. D. or other

Address Fitzpatrick Date signed 1-27-46

RECEIVED

FEB 1 1946

BUREAU VER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
 County Prince George
 City or town Hyattsville Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 1/2 years
 Hospital, institution, or street address where death occurred:
 Sacred Heart Home
 How long in hospital or institution? 6 1/2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State District of Columbia County
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 823 - N Capital
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

MARY FITZGERALD

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) 1857
 8. AGE: Years 88 Months - Days - If less than one day hrs. min.

9. Birthplace Wash. D.C.
 (Town, county, and state)
 10. Usual occupation none
 11. Industry or business

12. Name DAVID FITZGERALD
 13. Birthplace IRELAND
 14. Maiden name JOHANNA (UNKNOWN)
 15. Birthplace IRELAND

16. Informant Sacred Heart Home
 Address Hyattsville, Md.
 17. Burial Date thereof Jan 18 - 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt Carmel
 Localoo Washington D.C.
 T & Costello

18. Funeral director
 Address 1722 North Capitol St Wash DC
 19. January 15, 1946 Janus Dewey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1946 at 6 P M
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1 1945 to Jan 15 1946
 and that I last saw him alive on Jan 14 1946

Immediate cause of death Coronary Thrombosis
 Due to Arteriosclerotic heart disease
 Due to
 Other conditions

DURATION
 3 days

(Include pregnancy within 3 months of death)
 Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Thomas Hall
 M. D. or other
 Address 322 Hill me Date signed 1-15-46

RECEIVED

JAN 18 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 166

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges
City or town Chillum
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
716 Chillum Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Prince Georges County Prince Georges
City or town Chillum
(If outside city or town limits, write RURAL and give nearest town)
Street No. 716 Chillum Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mary Arine Fitzgerald

3. (b) Social Security Number

4. Sex

Female White Single

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 3, 1943

8. AGE:

Years 2 Months 7 Days 24 It less than one day
.....hrs.min.

9. Birthplace

Washington DC
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

20. Date signed

21. Signature

22. Address

23. Date signed

24. Date signed

25. Date signed

26. Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 27, 1946 at 3:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....(City or town).....(County).....(State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....Injured at work?.....

23. SIGNATURE.....M. D. or other.....

Address.....Date signed.....

24. SIGNATURE.....Date signed.....

25. SIGNATURE.....Date signed.....

26. SIGNATURE.....Date signed.....

27. SIGNATURE.....Date signed.....

28. SIGNATURE.....Date signed.....

29. SIGNATURE.....Date signed.....

30. SIGNATURE.....Date signed.....

31. SIGNATURE.....Date signed.....

32. SIGNATURE.....Date signed.....

33. SIGNATURE.....Date signed.....

34. SIGNATURE.....Date signed.....

35. SIGNATURE.....Date signed.....

36. SIGNATURE.....Date signed.....

37. SIGNATURE.....Date signed.....

38. SIGNATURE.....Date signed.....

39. SIGNATURE.....Date signed.....

40. SIGNATURE.....Date signed.....

41. SIGNATURE.....Date signed.....

42. SIGNATURE.....Date signed.....

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CENTRALIZATION OF RECORDS

RECEIVED
FEB 1 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 166

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George'sCity or town Chillum
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 1/2 yearsHospital, institution, or street address where death occurred:
716 - Chillum Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Chillum
(If outside city or town limits, write RURAL and give nearest town)Street No. 716 - Chillum Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Ardella Fitzgerald

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

John Henry Fitzgerald6.(c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.)

June 25, 1921

8. AGE:

Years

Months

Days

If less than one day

2472

.....hrs.min.

9. Birthplace

Chillum Md
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

FATHER

12. Name

George W Chapman

13. Birthplace

Maryland

MOTHER

14. Maiden name

Cora B. Arrowsmith

15. Birthplace

Maryland

16. Informant

Margaret Chapman

Address

716 - Chillum Rd

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan 30, 1946
(month) (day) (year)

Cemetery or crematory

Fort Lincoln

Location

Colmar Manor Md

18. Funeral director

F. Gasch's sons

Address

Hyattsville Md.

19. Date rec'd by registrar

Jan 30 '46

19. Date

James Sevier

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1946, at 3:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Hemorrhage and shock

Due to

gun shot wound

Due to

gun head

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide homicide Date of 1-27-46Where did injury occur? Chillum P.D. Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury gun shot Injured at work? noReport medical examiner23. SIGNATURE James Sevier M. D. or otherAddress Forestdale Md Date signed 1-27-46

RECEIVED
FEB 1 1946
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year
of birth of deceased is
shown on

FILM No. I 00 FEB 5 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prin George

City or town Bowie
(if outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Trangland County Prin George

City or town Bowie
(if outside city or town limits, write RURAL and give nearest town)

Street No. Samuel - Bowie Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret Ellen Fletcher

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Thomas P. Fletcher

deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1856 1865

8. AGE: Years 80 Months 5 Days 17 If less than one day
hrs. min.

9. Birthplace Quantico, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business House

12. Name Columbus Messick

13. Birthplace Quantico Md.

14. Maiden name Marietta Penables

15. Birthplace Quantico Md.

16. Informant Mrs. Mabel P. Thornton

Address Bowie, Md.

17. Burial Date thereof Jan 29, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Quantico, Md.

18. Funeral director W. H. H. H. H. H.

Address Laurel, Md.

19. Jan 29 19 46 Mrs. J. W. Guehring
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 19 46 at 8:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 19 40 to Jan 26 19 46
and that I last saw her alive on Jan 26 19 46

Immediate cause of death Cancer of colon (#46)

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURES

Robert S. G. Lerner M.D.
Address Laurel Md. Date signed 1/26/46

RECEIVED
FEB 1 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(32)

CERTIFICATE OF DEATH

Reg. Dist. No. 00815 231

1. PLACE OF DEATH:

County Prince Geo
 City or town Chesapeake, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Prince Geo. gen. Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Prince Geo
 City or town Greenbelt PO #83
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Furey Mrs. Nellie
 4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife John Henry
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 29, 1868

8. AGE: Years 77 Months 6 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Wisc.
 (Town, county, and state)

10. Usual occupation H. W.

11. Industry or business _____

12. Name August - Janet

13. Birthplace Trace

14. Maiden name Catherine Neeking

15. Birthplace Nova Scotia

16. Informant Furey, Miss Beatrice (daughter)

Address PO #83 - Greenbelt, Md.

17. Burial Date thereof Jan 5, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ammendale Cemetery

Location Ammendale, Md.

18. Funeral director W. W. Chambers Co.

Address Riverdale, Md.

19. 1/4 46 Amanda Downey
 (Date rec'd by registrar) (year) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Tues. Jan 1st 19 46 at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 29 19 45 to Jan 1st 19 46.

and that I last saw her alive on Jan 1st 19 46.

Immediate cause of death toxemia

DURATION

Due to infectious distemper

Causes undetermined

Due to _____

Other conditions Hypertensive Cardiovascular

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. M. Jorwig

Address Prince Geo. Ben Boy M. D. or other _____

Date signed 1-2-46

RECEIVED

JAN 9 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

CERTIFICATE OF DEATH

0816 245
Reg. Dist. No.

1. PLACE OF DEATH:
County... Prince Georges
City or town... Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hr.
Hospital, institution, or street address where death occurred:
5602-36th Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland County... Prince Georges
City or town... Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5602-36th Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Alan Garrett

3. (b) Social Security Number

4. Sex male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1945 6. (c) If alive, give age years

8. AGE: Years 20 Months Days If less than one day hrs. min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Hyatt Garrett 13. Birthplace District of Columbia

14. Maiden name Connie Holloway 15. Birthplace Indiana

16. Informant Mrs. Connie Garrett Address 5602-36th Place Hyattsville

17. Removal Date thereof Jan 20, 1946 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Local funeral home Location 6400 Washington St.

18. Funeral director L. Paschi sons Address Hyattsville Md.

19. Jan. 20, 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20, 1946, at 9:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19... and that I last saw him alive on 19...

Immediate cause of death Asphyxia

Due to Sma. thrombosis

Due to his old

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of 1-20-46

Where did injury occur? Hyattsville (City or town) Prince Georges (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of Injury Brothers in bed Injured at work? 1-20-46

Keepsite medical examine

23. SIGNATURE James D. Garrett M. D. or other

Address Hyattsville Md. Date signed 1-20-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

RECEIVED
JAN 22 1946
BUREAU T S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

00817

Reg. Diat. No. 239

1. PLACE OF DEATH:

County Prince Georges
 City or town Rural - Near Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 7/26/44
 Hospital, institution, or street address where death occurred:
Laurel Sanitarium
 How long in hospital or institution? Since 7/26/44

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State New Jersey County Not Known
 City or town Bohaca
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 241 Larch St. Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Clara O'Brien Gibbs

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Burton O. Gibbs7. Birth date of deceased (mo., day, yr.) September 27, 1872 6. (c) If alive, give age years8. AGE: Years 73 Months 3 Days 13 If less than one day hrs. min.9. Birthplace California (Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Mabel O'Brien13. Birthplace New York14. Maiden name Joanna Chung15. Birthplace Ireland16. Informant Miss Catherine GibbsAddress 4131-P St. NW - Washington D.C.17. REMOVAL (Burial, cremation, or removal, Which?) Date thereof JAN 31, 1946 (month) (day) (year)Cemetery or crematory HILLSIDE CEM.Location ARLINGTON CO. N. J.18. Funeral director WILLIAM COOK, INC.Address 1217 ST. PAUL ST.19. 1-25-46 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1946 at 11:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7, 1945 to January 19, 1946and that I last saw him alive on January 19, 1946Immediate cause of death Coronary Occlusion (acute) DURATION 3 hoursDue to Severe Arteriosclerosis Not Known

Due to

Other conditions Spile psychosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Laurel Sanitarium M. D. or otherAddress Laurel The Date signed 1/20/46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. CAUSE OF DEATH

11. DISEASE OR INJURY

12. MANNER OF DEATH

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF DECEASED

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF BURIAL SOCIETY

19. SIGNATURE OF INTERMENT SOCIETY

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

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29. SIGNATURE OF OTHER

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32. SIGNATURE OF OTHER

33. SIGNATURE OF OTHER

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36. SIGNATURE OF OTHER

37. SIGNATURE OF OTHER

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39. SIGNATURE OF OTHER

40. SIGNATURE OF OTHER

41. SIGNATURE OF OTHER

42. SIGNATURE OF OTHER

43. SIGNATURE OF OTHER

44. SIGNATURE OF OTHER

45. SIGNATURE OF OTHER

46. SIGNATURE OF OTHER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

CERTIFICATE OF DEATH

★ Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George
City or town Chesley, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hr.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Prince George
City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6501 - Dorsey Rd. SE
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME

George William Gray

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower

6. (b) Name of husband or wife Mary J. Bowles
(deceased)

7. Birth date of deceased (mo., day, yr.) 1861 6. (c) If alive, give age 19 years

8. AGE: Years 84 Months 1 Days 22 If less than one day hrs. min.

9. Birthplace Chaptico - St. Mary's County, Maryland
(Town, county, and state)

10. Usual occupation Farm produce merchant

11. Industry or business

12. Name George E. Gray

13. Birthplace Maryland

14. Maiden name Margaret Harris

15. Birthplace Unknown

16. Informant Mr. Melvin Moore

Address 6501 - Dorsey Rd, S.E. - Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan 9, 1946
(month) (day) (year)

Cemetery or crematory St. Charles

Location Shanterville, Maryland

18. Funeral director Robert Mattingly

Address 131 - 11th St, S.E. - Washington, D.C.

19. (Date rec'd by registrar) 1/10/46 Registrar Chesley, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6-46 at 6:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12, 1943 to Jan 6, 1946

and that I last saw him alive on Jan 4, 1946

Immediate cause of death Intestinal Obstruction DURATION 3 days

Due to Unknown

Due to

Other conditions Ch. Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J. Maloney, M.D.

Address Chesley, Md. Date signed Jan 6, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The information is especially important. Physicians: please write the causes of death clearly and legibly.

NEWLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

RECEIVED
JAN 9 1946
BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

CERTIFICATE OF DEATH

Reg. Diat. No. 240

1. PLACE OF DEATH:

County Prince GeorgesCity or town Cheltenham, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Cheltenham, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Robert Lee Hall

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed8. (b) Name of husband or wife Miss E. Campbell7. Birth date of deceased (mo., day, yr.) July 4 - 1868. 8. (c) If alive, give age years8. AGE: Years 77 Months 6 Days 1 If less than one day hrs. min.9. Birthplace Cheltenham P. Co. Co., Md.
(Town, county, and state)10. Usual occupation Farm11. Industry or business William H. Hall12. Name William H. Hall13. Birthplace Forestville, Md.14. Maiden name Esther E. Talbot15. Birthplace Cheltenham, Md.16. Informant Miss Helen H. WhiteAddress 1911 - 24th St., Washington, D.C.17. Burial Date thereof Jan. 8 - 46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Forest Hill Burial GroundLocation Cheltenham, Md.18. Funeral director William H. HallAddress 1911 - 24th St., Washington, D.C.19. Jan. 7, 1946 20. F. H. Billingsley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 19 46 at 6 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5, 1945 to Jan 4 19 46 and that I last saw him alive on Jan 4 19 46Immediate cause of death Cerebral hemorrhage with Paralytic stroke
Due to General arteriosclerosis
Due to arteriosclerosis

DURATION

1 day

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul E. SmithAddress Washington 19 DC Date signed 1/4/46

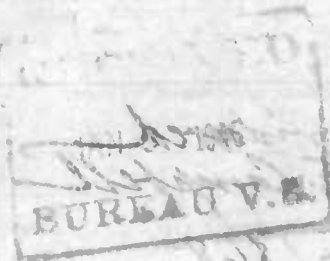
CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

REGISTRATION



John W. Smith

John W. Smith

John W. Smith

John W. Smith

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... *Prince George*City or town..... *Mayfield, Md*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas Harper

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Caucasian

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Dora Harper

7. Birth date of deceased (mo., day, yr.)

Dec, 25 1870

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

*75**0**7*

hrs.

min.

9. Birthplace

Prince George County
(Town, county, and state)

10. Usual occupation

Teacher

11. Industry or business

FATHER

12. Name

Thomas Harper

13. Birthplace

Md.

MOTHER

14. Maiden name

Sarah (unknown)

15. Birthplace

Md.

16. Informant

Frank Harper

Address

Waldorf, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 9/46
(month) (day) (year)

Cemetery or crematory

Brookside Chapel

Location

Waldorf, Md.

18. Funeral director

Address

J-B Johnson

19.

(Date rec'd by registrar)

19.

Jan 9 1946
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 6

19.

46

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan.

19.

11/8

to

1946

and that I last saw him alive on

11/8

19.

46

Immediate cause of death

*Cardiac
decompensation*

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. A. Webster, M.D.
M. D. or other

Address

Waldorf, Md.

Date signed

1/14/46

JAN 11 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-2

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince GeorgeCity or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 77-U-St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret Lyon Hunt

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed6. (b) Name of husband or wife George M. Hunt7. Birth date of deceased (mo., day, yr.) March 8th 1859

8. AGE: Years Months Days It less than one day

86 hrs. min.8. Birthplace Washington D.C.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Estelle HuntAddress 77-U-St. N.W.17. Burial Date thereof Jan. 30-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GlenwoodLocation Washington D.C.18. Funeral director Wm. J. GallyAddress 3200-R.I. Ave. Mt. Rainier Md.19. Jan. 29 1946 James Bevers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1946 at 5:45 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1945, to Jan. 27 1946and that I last saw her alive on Jan. 26 1946

Immediate cause of death

Acute Dilatation of Heart

DURATION

2 mins

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Charles C. Shrage M.D.Address Mt. Rainier, Md. Date signed Jan. 28, 1946

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

MASSACHUSETTS DEPARTMENT OF HEALTH

RECEIVED

FEB 1 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince Georges
 City or town Rural - Near Laurel
 (If outside city or town limits, write RURAL, and give nearest town)
 How long in above place of death? Since 3/9/45
 Hospital, institution, or street address where death occurred:
Laurel Sanitarium
 How long in hospital or institution? Since 3/9/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County Washington
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1519 Montara Ave N.E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

William F Hunter

3. (b) Social Security Number

Not Known

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

Not Known

7. Birth date of deceased (mo., day, yr.)

August 13 - 1864

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

8153

hrs.

min.

9. Birthplace

Westminster Md
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Robert Hunter

12. Name

Maryland

13. Birthplace

Mary Davis

14. Maiden name

Maryland

15. Birthplace

H. F. Hunter

16. Informant

(Same as deceased)

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

1/19/46
(month) (day) (year)

Cemetery or crematory

Westminster Cemetery

Location

Westminster, Md.

18. Funeral director

J. E. Dwyer Jr.

Address

Westminster, Md.

19. Jan 16

(Date rec'd by registrar)

19. 46

M. Brashear

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 16 1946 at 1:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/9 1945 to 1/16 1946and that I last saw him alive on January 16 1946

Immediate cause of death

Cerebral arteriosclerosis

Due to

General Arteriosclerosis

Due to

Other conditions

Senile psychosis

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

J. M. Meene

M. D. or other

Address

Laurel Sanitarium

Date signed

1/16/46Laurel, Md.

RECEIVED

JAN 19 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1150

CERTIFICATE OF DEATH

Reg. Dist. No.

00823 245

1. PLACE OF DEATH:

County.....*Pr. Geo. Co.*
 City or town.....*Riversdale, Md.*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Deland Mun. Hosp

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Md.* County.....*Pr. George*City or town.....*Greenbelt*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....*54 - L. Ridge Rd*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Michael Lodico Jeffry

3. (b) Social Security Number

*578-36-3281*4. Sex.....*M*5. Color or race.....*W*6. (a) Single, married, widowed, or divorced.....*married*6. (b) Name of husband or wife.....*Myrtle S. Jeffry*

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....*March - 8 - 1913*8. AGE: Years.....*32* Months..... Days..... If less than one day..... hrs. min.9. Birthplace.....*Phila, Pa*

(Town, county, and state)

10. Usual occupation.....*Printer*

11. Industry or business.....

12. Name.....*Salvatore Jeffry*13. Birthplace.....*Italy*14. Maiden name.....*Maria Lodico*15. Birthplace.....*Italy*16. Informant.....*Myrtle S. Jeffry*Address.....*54 - L. Ridge Rd. Greenbelt Md*17. Burial.....*Burial*

(Burial, cremation, or removal, Which?)

Date thereof.....*Jan 14 1946*

(month) (day) (year)

Cemetery or crematory.....*Arlington Natl Cemetery*Location.....*Arlington Va.*18. Funeral director.....*St. W Chambers Co.*Address.....*Riversdale Md.*19. Date rec'd by registrar.....*Jan 13 1946*Registrar.....*James Severy*

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*1-11*..... 19*46*, at.....*11:20 AM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....*11/30*..... 19*45*, to.....*1/11*..... 19*46*and that I last saw him alive on.....*1/11*..... 19*46*Immediate cause of death.....*Registery*.....*failure*Due to.....*Esther shock*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....*Chronic tonsillitis*Date of op.....*11/11/46*

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*William Eisner MD*Address.....*Greenbelt Md*Date signed.....*1/11/46*

RECEIVED
JAN 16 1945
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince George's
 City or town..... (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 1 yr., 7 mos., 15 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution?..... 1 yr., 7 mos., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 115 1st St. N. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... - ✓

3. (a) FULL NAME

ALFRED JENNETT

3. (b) Social Security Number

-

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife..... Lillie Jennett (deceased)

7. Birth date of deceased (mo., day, yr.)

March 29, 1876

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

69

9

5

.....hrs.min.

9. Birthplace..... Science Ridge, Kentucky

(Town, county, and state)

10. Usual occupation.....

Carpenter's Helper

11. Industry or business

FATHER

12. Name.....

Newt Jennett

13. Birthplace.....

Jeffersonville, Kentucky

MOTHER

14. Maiden name.....

Seanie Anderson

15. Birthplace.....

Jeffersonville, Kentucky

16. Informant.....

Decedent

Address

17. Removal (Burial, cremation, or removal. Which?)

Removal

Date thereof.....

Jan. 5-1946
(month) (day) (year)

Cemetery or crematory.....

Location.....

Washington D.C.

18. Funeral director.....

Address.....

James J. Brown Inc

19. (Date rec'd by registrar).....

19

45 Rowland S. Phillips

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... JAN. 3, 1946, at 2:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19, 1944, to Jan. 3, 1946

and that I last saw him alive on Jan. 3, 1946

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

2 yr. 1 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

Daniel Leo Pinuccine MD
Address: Glenn Dale, Md. Date signed: 1/3/46

RECEIVED
JAN 11 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 225

1. PLACE OF DEATH:

County Prince GeorgesCity or town Green Meadows
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Green Meadows
(If outside city or town limits, write RURAL and give nearest town)Street No. 6511- Sligo Parkway
(If rural, give LOCATION)

2.(c) If veteran, name war

3. (a) FULL NAME

ALMA C. JENNINGS

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

R. Elmer Jennings

7. Birth date of deceased (mo., day, yr.)

May 25, 1893

8. AGE: Years Months Days If less than one day

52 hrs. min.9. Birthplace Willis, Virginia
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Amos D. Vaughn13. Birthplace Willis, Va.14. Maiden name Cora Bolt15. Birthplace Willis, Va.16. Informant George R. SheppAddress Laurel, Md. R.F.D. #317. Burial Date thereof Jan. 25, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Fort Lincoln CemeteryLocation 3201-Bladensburg Rd. Md.18. Funeral director William J. HalleyAddress 3200-R. I. Ave. Mt. Rainier, Md.Jan 24 1946 James SEVEY
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1946 at 3 50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 3 1945 to Jan 23 1946and that I last saw him alive on Jan 22 1946Immediate cause of death Pulmonary EdemaDue to Cerebral HemorrhageDue to Pericardial HypertensionOther conditions G. V. R.Uremia

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard Shaw M.D.Address 1324 Michigan Ave. Wash DCDate signed 1-23-46

RECEIVED
JAN 26 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

04826

★ Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince GeorgesCity or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 29 days

Hospital, institution, or street address where death occurred:

Leland Memorial HospitalHow long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 734 19th St. N.E.
(If rural, give LOCATION) ✓

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. George Minor Jett

3. (b) Social Security Number

4. Sex

male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife ?7. Birth date of deceased (mo., day, yr.) ?, ?, 1858

6.(c) If alive, give age years

8. AGE: Years 87 Months ? Days ? If less than one day
.....hrs.min.9. Birthplace ? Virginia
(Town, county, and state)10. Usual occupation Retired11. Industry or business Retired12. Name Stapleton Freshfield Jett13. Birthplace ? Virginia14. Maiden name Fally Blackson15. Birthplace ?16. Informant Leland Memorial Hospital RecordsAddress Riverdale, Md.17. removal Date thereof Jan. 18, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Stephen CemeteryLocation Deal Funeral Home18. Funeral director Deal Funeral HomeAddress 4812 E. Ave. N.W. Wash, D.C.19. Jan 18, 1946 Registrar James Devry

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1946 at 10:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 20, 1945 to Jan. 18, 1946and that I last saw him alive on 1-17-46Immediate cause of death Cerebral thrombosis

DURATION

2 Mo.Due to General arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L.H. Mahan MD

M. D. or other

Address Riverdale, Md. Date signed 1-18-46

RECEIVED
JAN 21 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (232)

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County... Prince George's
City or town... Fairmount Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred:
613 - 61 Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Va County... Louisa
City or town... Bumpass Va
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Byron Johnson
3. (b) Social Security Number

4. Sex Male
5. Color or race Colored
6. (a) Single, married, widowed, or divorced married
B. (b) Name of husband or wife Sarah Johnson
6. (c) If alive, give age 76 years
7. Birth date of deceased (mo., day, yr.) July 28 1865-
8. AGE: Years 80 Months 6 Days If less than one day hrs. min.

9. Birthplace Bumpass Va
(Town, county, and state)
10. Usual occupation Farmer

11. Industry or business
12. Name Edward Johnson
13. Birthplace Va
14. Maiden name Julia Costes
15. Birthplace Va

16. Informant Mrs Bessie Jackson
Address 218 - N Baxon St Phila Pa
Transportation Date thereof Jan 11 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory
Location 467 - 7th St. N.W. Wash. DC
18. Funeral director J.B. Johnson
Address Annapolis

19. Jan 8 - 19 46 Irene G. Bremer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 19 46 5:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 9 19 46 to Jan 8 19 46
and that I last saw him alive on Jan 7 19 46

Immediate cause of death M. Kemia
Due to Cerebral Hemorrhage - Hypertension
Due to Essential (Hypertension)
Other condition Gen. Arteriosclerosis
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Robert R. Nelson, M.D.
Address 4112 Grand St. NE Washington, DC
Date signed 1/8/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 18 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-2

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH: County... <u>Prince George's</u> City or town... <u>(rural) Glenn Dale, Maryland</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>5 mos., 25 days</u> Hospital, institution, or street address where death occurred: <u>Glenn Dale Sanatorium</u> How long in hospital or institution? <u>5 mos., 25 days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>D. C.</u> County..... City or town... <u>Washington</u> (If outside city or town limits, write RURAL and give nearest town) Street No... <u>1757 Church St. N. W.</u> (If rural, give LOCATION) 2.(a) If veteran, name war..... ✓			
3. (a) FULL NAME <u>Betty Kaufman</u>				3. (b) Social Security Number <u>None</u>			
4. Sex <u>F</u> 5. Color or race <u>W.</u> 6. (a) Single, married, widowed, or divorced <u>Single</u>				MEDICAL CERTIFICATION			
6. (b) Name of husband or wife				20. DATE OF DEATH <u>January 25</u> 19 <u>46</u> , at <u>10³⁰ P. M.</u>			
7. Birth date of deceased (mo., day, yr.) <u>August 11, 1921</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>July 31</u> 19 <u>45</u> , to <u>Jan 25</u> 19 <u>46</u> and that I last saw him/her alive on <u>January 25</u> 19 <u>46</u>			
8. AGE: Years <u>24</u> Months <u>5</u> Days <u>14</u> If less than one day hrs. min.				Immediate cause of death <u>Tuberculosis, pulmonary</u> DURATION <u>11 mo.</u>			
9. Birthplace <u>Washington, D. C.</u> (Town, county, and state)				Due to.....			
10. Usual occupation <u>Government Clerk</u>				Due to.....			
11. Industry or business				Other conditions.....			
12. Name <u>Peter Kaufman</u>				(Include pregnancy within 3 months of death)			
13. Birthplace <u>Greece</u>				Major findings of operations			
14. Maiden name <u>Lulu Kaufman</u>				Date of op.			
15. Birthplace <u>Greece</u>				Autopsy results			
16. Informant <u>Decedent</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
Address				22. VIOLENCE: If death was due to external causes, fill in the following:			
17. Burial, cremation, or removal (Which?) <u>Removal</u> Date thereof <u>1. 26. 46</u> (month) (day) (year)				Accident, suicide, or homicide..... Date of.....			
Cemetery or crematory <u>Washington</u>				Where did injury occur? (City or town) (County) (State)			
Location <u>D.C.</u>				Injured at home, farm, industry, public place (where?)			
18. Funeral director <u>Deals Funeral Home</u>				Means of injury Injured at work?			
Address <u>4812 Latrobe N.W. Washington, D.C.</u>				23. SIGNATURE <u>Daniel Leo Pinucane MD</u> M. D. or other			
19. Date rec'd by registrar <u>Jan 25, 1946</u> Registrar <u>Rowland Phillips</u>				Address <u>Glenn Dale, Md</u> Date signed <u>1/25/46</u>			

RECEIVED
FEB 1 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince GeorgesCity or town Clinton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Clinton
(If outside city or town limits, write RURAL and give nearest town)Street No. none

(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME

Harriett Kuell

3. (b) Social Security Number

4. Sex Female 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife William R. Kuell

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) January 28, 18798. AGE: Years 66 Months 11 Days 10 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John Thomas King13. Birthplace Maryland14. Maiden name Mary Ann Nalley15. Birthplace Maryland16. Informant William R. KuellAddress Clinton, Maryland17. Burial Date thereof Jan. 10, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. John's Church CemeteryLocation Clinton, Maryland18. Funeral director James E. Ryan, Inc.Address 317 Penna. Ave., S.E.19. 1-9- 46 Thos J. Griffiths
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 19 46, at 11 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7 19 45 to Jan 9 19 46
and that I last saw her alive on Jan 8 19 46Immediate cause of death a pulse
Bronchopneumonia DURATION 12 mo

Due to _____

Due to _____

Other conditions Cirrhosis of liver
atrophic
(Include pregnancy within 3 months of death)Major findings of operations Cirrhosis of liver Dec 1944
Providence Hospital Date of op. Dec 15/1944Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Thos J. Griffiths M. D. memberAddress Washington 19 DC Date signed Jan 9 1946

RECEIVED

RECEIVED

RECEIVED

MAR 18 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH:

County Prince George
 City or town Prince George Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Leri H. King

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Catherine G. Ball

6. (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Nov. 29 - 1860

8. AGE: Years 85 Months 1 Days 23 If less than one day hrs. min.

9. Birthplace Pr. Geo. Co. Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Leri King

12. Name Leri King

13. Birthplace Bladensburg, Md.

14. Maiden name Rebecca Jones

15. Birthplace Pr. Geo. Co., Md.

16. Informant Joseph Leri King (son)

Address Prince George, Md.

17. Burial Date thereof 1-25-46 (month) (day) (year)

Cemetery or crematory Mr. Carmel

Location Upper Marlboro, Md.

18. Funeral director Ridgely Brothers

Address Upper Marlboro, Md.

19. Jan 24 46 Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George

City or town Prince George Rural
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 19 46 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 19 44 to Jan 22 19 46

and that I last saw him alive on Jan 15 19 46

Immediate cause of death Cerebral Hemorrhage

Due to Nephritis

Due to _____

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations none

Antopsy results NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James B. Pearson M. D. or other

Address Upper Marlboro, Md. Date signed 1-23-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 26 1946
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

CERTIFICATE OF DEATH

0082030
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince Georges
 City or town Berwyn
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death Transient
 Hospital, institution, or street address where death occurred:
Rhode Island Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Berwyn
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 8704 - Rhode Island Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Jeddy Eugene Lambert

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Aug 26 1937

8. AGE: Years 8 Months 4 Days 21 If less than one day
 _____ hrs. _____ min.

9. Birthplace Virginia
 (Town, county, and state)

10. Usual occupation Student

11. Industry or business

12. Name James E. Lambert

13. Birthplace Virginia

14. Maiden name Lula Margaret Berger

15. Birthplace Va.

16. Informant Mrs. James E. Lambert

Address 8704 Rhode Island Ave Berwyn

17. Burial Date thereof Jan 20 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Berwyn VA

18. Funeral director 7 Jacob's Sons

Address Hyattsville Md

19. January 18 1946 John D. Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 19 46 at 8:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____ DURATION

Non-fatal anoxia
shock
 Due to crushed skull
fractured left femur
 Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 1-17-46

Where did injury occur? Berwyn (City or town) Prince Georges (County) MD (State)

Injured at home, farm, industry, public place (where?) Rhode Island Ave

Means of injury Rain in front truck Injured at work? no

deputy medical examiner

23. SIGNATURE James E. Lambert M. D. or other

Address Berwyn VA Date signed 1-17-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dangerville Va.

REC'D

JAN 19 1945

BUREAU V. S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Prince Georges Registration Dist. No. 234-725
 Village or City Piscataway No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

Irene Lancaster
 (a) Residence: No. Piscataway St. _____ Ward _____
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Col.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>David T. Lancaster</u>		
6. DATE OF BIRTH (month, day, and year) <u>June 20 - 1888</u>		
7. AGE Years <u>59</u>	Months <u>6</u>	Days <u>15</u>
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Housewife</u>		11. Total time (years) spent in this occupation <u>40 yrs</u>
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>7</u>		
10. Data deceased last worked at this occupation (month and year) <u>Dec 29/45</u>		
12. BIRTHPLACE (city or town) (State or country) <u>Charles Co Md</u>		
13. NAME <u>John Robinson</u>		
14. BIRTHPLACE (city or town) (State or country) <u>Charles Co Md</u>		
15. MAIDEN NAME <u>Laura Ferguson</u>		
16. BIRTHPLACE (city or town) (State or country) <u>Charles Co Md</u>		
17. INFORMANT <u>Irene Lancaster</u> (Address) <u>Windsor, Md</u>		
18. BURIAL, CREMATION, OR REMOVAL Place <u>Piscataway</u> Date <u>Jan 5 - 1945</u>		
19. UNDERTAKER <u>The Mc Guire Funeral Service</u> (Address) <u>1820-22-24 North St Wash DC</u>		
20. FILED <u>1-2</u> 19 <u>46</u> in <u>P. S. No. 1</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Jan 1st 1945
 (Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from Jan 30 1945 to Jan 1st 1946

I last saw her alive on Dec 30 1945; death is said to have occurred on the data stated above, at 11:45 AM

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Date of onset

Angina Pectoris

Other Contributory Causes of Importance:

arterio-sclerosis 80%

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____ 19 _____

Where did injury occur? _____

(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) John E. Powers M. D.(Address) Grandview, Md

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927
Other contributory causes of importance:	
Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago
Other contributory causes of importance:	
Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B.C.

CERTIFICATE OF DEATH

00831

★ Reg. Dist. No. 243

1. PLACE OF DEATH:

County... Prince George's
 City or town... (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... D. C. County...
 City or town... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 820- 6th St. N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... - ✓

3. (a) FULL NAME

CHANG LEE

3. (b) Social Security Number

None

4. Sex Male 5. Color or race Chinese 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Un Lee
 7. Birth date of deceased (mo., day, yr.) May 14, 1898
 6. (c) If alive, give age ? years
 8. AGE: Years 47 Months 7 Days 28 If less than one day
 hrs. min.

9. Birthplace Canton, China
 (Town, county, and state)
 10. Usual occupation Cook
 11. Industry or business
 12. Name You Chang Lee
 13. Birthplace Canton, China
 14. Maiden name Su Lee
 15. Birthplace Canton, China

16. Informant Decedent
 Address

17. Burial Date thereof 1-12-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Fort Lincoln Cemetery
 Location Washington D.C.

18. Funeral director J. William Lee & Sons
 Address 300-4th St. N.E.

19. Jan 11, 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11, 1946, at 3:20 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 to Jan 11, 1946, to Jan 11, 1946, and that I last saw him alive on Jan 11, 1946.
 Immediate cause of death

Pulmonary Tuberculosis
 DURATION 2 mo.

Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinucene M.D.
 Address Glenn Dale, Md. Date signed 1/11/46

RECEIVED
JAN 16 1946
BUREAU V.S.

RECEIVED

JAN 16 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

CERTIFICATE OF DEATH

Reg. Dist. No. 00822
245

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Sargent Rd NE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... MD County..... Prince Georges
 City or town..... Sargent Rd NE
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Charlotte M. C. Miller

3. (b) Social Security Number

4. Sex..... F 5. Color or race..... W 6.(a) Single, married, widowed, or divorced..... S

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)..... Sept 25 1875 8.(c) If alive, give age..... years

8. AGE: Years..... 70 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... D. C.
 (Town, county, and state)

10. Usual occupation..... None

11. Industry or business

12. Name..... Wm. C. Miller
 13. Birthplace..... Ireland

14. Maiden name..... Kathryn Smith
 15. Birthplace..... Wash DC

16. Informant..... Miss Miller
 Address..... 1458 Col Rd NE

17. (Burial, cremation, or removal. Which?)..... Removal Date thereof..... 1-6-46
 (month) (day) (year)

Cemetery or crematory..... Poplar Ave Cem
 Location..... Wash DC

18. Funeral director..... Hunterman Funeral Home
 Address..... 5732 Ga Ave

19. Jan 6 1946 Registrar..... James Severy
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 6 1946 at..... 8:20 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... Aug 12 1945 to..... Jan 6 1946
 and that I last saw him alive on..... Jan 6 1946

Immediate cause of death..... Cerebral thrombosis

Due to..... Hypertension

Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

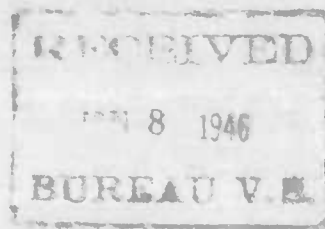
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Wm. H. Foster M. D. or other.....

Address..... 3527-3495 Date signed.....
Int Examiner, Md.

Had cerebral accident Aug. 11, 45. Causing paralysis
of rt arm & leg. Had partial recovery then had
another cerebral hemorrhage Dec. 1, 45 and
gradually grew weaker since that date finally
became comatose Jan. 4, 46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Sacred Heart Home
How long in hospital or institution? 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Pr. George
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Sacred Heart Home
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

MARY V. MURPHY.

3. (b) Social Security Number

None.

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) August 15, 1858? 6.(c) If alive, give age - years
8. AGE: Years 87? Months 5 Days 3 If less than one day - hrs. - min.

9. Birthplace Kilbuck, Illinois
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Michael Murphy

13. Birthplace Ireland

MOTHER 14. Maiden name Abigail Burke

15. Birthplace Ireland

16. Informant Sacred Heart Home Records

Address Hyattsville Maryland

17. Burial Burial Date thereof Jan 19, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Albans Cemetery

Location Washington, D.C.

18. Funeral director James E. Ryan, Inc.

Address 317 Pa. Ave. S. E.

19. Jan. 18 " 46 James Severy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1946 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5, 1946 to Jan. 18, 1946 and that I last saw him alive on Jan. 17, 1946.

Immediate cause of death Chronic Myocarditis. DURATION 2 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Connor, M.D. M. D. or other

Address 2026-16th St. N.W. Date signed 1/18/46
Washington 9, D.C.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED

JAN 24 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

01077

242

Reg. Dist. No.

1. PLACE OF DEATH:

County Prince Georges
 City or town Chapel Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Permanent
 Hospital, institution, or street address where death occurred:
1443-58th Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Chapel Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5009 Nye
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William Edward Nichols

3. (b) Social Security Number

4. Sex

male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

December 7, 1947

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

18120

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Chopper

11. Industry or business

William E. Nichols

12. Name

13. Birthplace

Maryland

14. Maiden name

Ella Wright

15. Birthplace

Maryland

16. Informant

Lawrence J. Nichols

Address

Chapel Hill, Md

17. (Burial, cremation, or removal. Which?)

removal

Date thereof

1-28-46

(month) (day) (year)

Cemetery or crematory

Forest Hill

Location

Forest Hill

18. Funeral director

Address

467 76 St. M.W.19. Jan 29/19 46

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 26, 1946, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to19.....

and that I last saw himalive on19.....

Immediate cause of death

Hemorrhageand shockgun shot woundof chest

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide homicide Date of 1-26-46Where did injury occur? Chapel Hill, Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) StreetMeans of injury shot with revolver Injured at work? noReport medical examiner23. SIGNATURE James V. Ford M. D. or otherAddress Forest Hill, Md Date signed 1-27-46

RECEIVED

MAR 18 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00835

Reg. Dist. No. 245

1. PLACE OF DEATH:
County PRINCE GEORGES
City or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 YEARS
Hospital, institution, or street address where death occurred:
SACRED HEART HOME
How long in hospital or institution? 16 YEARS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County PRINCE GEORGES
City or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. SACRED HEART HOME
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME
MARIA M. OTTO

3. (b) Social Security Number
No

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) SEPT. 7, 1859 6. (c) If alive, give age 86 years

8. AGE: Years 86 Months 3 Days 26 If less than one day hrs. min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual occupation NONE

11. Industry or business

12. Name CHRISTIAN OTTO

13. Birthplace GERMANY

14. Maiden name JUSTINA WEHMANN

15. Birthplace GERMANY

16. Informant SACRED HEART HOME RECORDS

Address HYATTSVILLE, MD.

17. BURIAL Date thereof JAN 7, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt Olivet Cemetery

Location Washington, D.C.

18. Funeral director Frankie J. Collins

Address 3821-14th St. N.W. Wash. D.C.

19. Jan 7 1946 James Beverly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 3 1946 at 8:10 P.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from JAN. 3 1946 to JAN 3 1946 and that I last saw him alive on JAN 3 1946

Immediate cause of death Coronary atherosclerosis
myocardial infarction
DURATION 5 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Robert B. Bader, M.D.

Address 355 My Ave Date signed Jan 4/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 8 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17023

CERTIFICATE OF DEATH

Reg. Dist. No.

00836

231

1. PLACE OF DEATH:

County Prince Georges
 City or town Chesapeake
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 week on arrival
 Hospital, institution, or street address where death occurred:
Prince Georges General
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County St. Mary's
 City or town Capitol Heights
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 336 - Southern Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Walter Franklin Phelps

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Alice Elizabeth Phelps
 7. Birth date of deceased (mo., day, yr.) Aug 8, 1873 B.(c) If alive, give age..... years
 8. AGE: Years 72 Months Days If less than one day
 hrs. min.

9. Birthplace Maryland
 (town, county, and state)
 10. Usual occupation night watchman
 11. Industry or business
 12. Name Phelps
 13. Birthplace unknown
 14. Maiden name Mrs. E. O'Neil
 15. Birthplace Maryland

16. Informant Mary E. Street
 Address 336 - Southern Avenue
 17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 1-26-46
 (month) (day) (year)
 Cemetery or crematory Oak Lawn Cemetery
 Location Baltimore Md
 18. Funeral director W. W. Chambers
 Address 517 - 11th St. SE, Washington D.C.
 19. 1/24 46 Unkaid Deane
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23, 1946 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19..... to19.....
 and that I last saw h..... alive on19.....

Immediate cause of death Heart failure
Shock
 Due to Coronary atherosclerosis
Myocardial infarction
with chronic heart failure
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of 1-23-46
 Where did injury occur? Capital Heights Md
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Central Ave
 Means of injury Automobile Injured at work? No

23. SIGNATURE John E. Street M. D. or other
 Address 336 - Southern Avenue Date signed 1-24-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

00837

Reg. Dist. No. 243

1. PLACE OF DEATH:

County... Prince George's
 City or town... (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr., 7 mos., 5 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution? 1 yr., 7 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D. C. County...
 City or town... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 1718- 29th St. S. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... -

3. (a) FULL NAME

CYRUS J. PHILLIPS

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Frances Phillips
 7. Birth date of deceased (mo., day, yr.) August 6, 1901
 8. AGE: Years 44 Months 4 Days 26 If less than one day ...hrs. ...min.
 8. (c) If alive, give age 41 years

9. Birthplace Washington, D. C.
 (Town, county, and state)
 10. Usual occupation Labor Foreman
 11. Industry or business

12. Name Albert Phillips
 13. Birthplace Washington, D. C.
 14. Maiden name Catherine Neurath
 15. Birthplace Washington, D. C.

16. Informant Decedent
 Address

17. Removal Date thereof Jan 2, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory to Washington, D. C.
 Location N. W. Chamber L.

18. Funeral director W. W. Chamber L.
 Address 617-11 N. SE

19. Jan 1, 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 1st 1946 at 3:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 27 1944 to JAN 1 1946
 and that I last saw him alive on JAN 1 1946

Immediate cause of death PULMONARY TUBERCULOSIS
 DURATION 2 yrs 7 mos.

Due to
 Due to

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinucare M.D.
 Address of Glenn Dale, Md. Date signed 1/1/46

RECEIVED
JAN 7 1946
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges

City or town Cottage City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince Georges

City or town Cottage City
(If outside city or town limits, write RURAL and give nearest town)Street No. 3711-37th Place
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

WILLIAM VANKIRK SCHWARM

3. (b) Social Security Number

160-12-0038

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

Willa R. Schwarm

7. Birth date of deceased (mo., day, yr.)

Dec. 4 - 1866

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

79

1

6

hrs.

min.

9. Birthplace

Pittsburgh, Pa.

(Town, county, and state)

10. Usual occupation

Maintenance Worker

11. Industry or business

Sheet Metal Warehouse

FATHER

12. Name

Jacob Schwarm

13. Birthplace

Germany

MOTHER

14. Maiden name

Schuler

15. Birthplace

Germany

16. Informant

Mr. James S. Schwarm

Address

3711-37th Pl. Cottage City, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 11, 1946
(month) (day) (year)

Cemetery or crematory

So. Side Cem.

Location

Pittsburgh, Penna.

18. Funeral director

S. H. Jones Co.

Address

2901-14th St. N.W., Wash., D.C.

19.

(Date rec'd by registrar)

19

46

Amanda Deuney

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10 1946 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 10 - 45 to 1/10 1946

and that I last saw him alive on 1/9 1946

Immediate cause of death Coronary Occlusion DURATION

PULMONARY PNEUMONIA

CONVALESCENT

Due to

Due to

Other conditions

(Include pregnancy within 9 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

George Hager

M.D. or other

Address 3711-37th Ave Date signed 1/13/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUN 14 1946
BUREAU V. R.

114

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137

00839

FILM No. I 0 0 FEB 12 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County Prince George
 City or town Warren Hospital Laurel, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Warren Hospital Laurel, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard
 City or town Fulton, Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Leonard Sealing

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

8. (b) Name of husband or wife

Katherine Bassett Sealing

8. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Aug. 22, 1860

8. AGE:

85

Years

Months

Days

If less than one day

56

hrs.

min.

9. Birthplace

Pfeiffers Corner, Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Herman Sealing

12. Name

Germany

13. Birthplace

Germany

14. Maiden name

Catherine ?

15. Birthplace

Germany

16. Informant

C. Harvey Sealing

Address

Laurel, Md.

17. Burial

St. Paul's Lutheran
(Burial, cremation, or removal, Which?)

Cemetery or crematory

Fulton, Md.

18. Funeral director

Easton Sons

Address

Ellicott City, Md.

19. Jan. 29, 1946

(Date rec'd by registrar)

19 46

John B. Loughman

Reg. B. E. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 28 1946, at 4:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1930, to Jan 28 1946and that I last saw him alive on Feb 28 1946

Immediate cause of death

Broncho Pneumonia

Due to

asthma = 1

Due to

Other conditionsEncephalitis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

B. P. HouseWarren HospitalLaurel, Md.

M. D. or other

Date signed 1-28-46

DURATION

2 wksSwissCheddar10 days

RECEIVED
FEB 5 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

FILM No. I O 1 MAR 13 1946

CERTIFICATE OF DEATH



Reg. Dist. No. 00840 245

1. PLACE OF DEATH:

County PRINCE GEORGE

City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Sacred Heart Home

How long in hospital or institution? 3

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County PRINCE GEORGE

City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

MARGARET RYDD SHINN

3.(b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOWED

8.(b) Name of husband or wife

JAMES W. SHINN

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) JULY 31, 1842

8. AGE:

Years	Months	Days	If less than one day
<u>102</u>	<u>103</u>	<u>6</u>	<u>21</u>
			hrs. min.

9. Birthplace

ALEXANDRIA VIRGINIA

(Town, county, and state)

10. Usual occupation

HOUSE WIFE

11. Industry or business

FATHER

12. Name JOHN ANDERSON RYDD

MOTHER

13. Birthplace ALEXANDRIA VA

14. Maiden name

SALLY PADGETT

15. Birthplace

UNKNOWN

16. Informant

Pauline D. Brayshaw

Address 207 S. Royal St. Alex Va.

17. BURIAL

Date received JAN 29, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

ST. PAUL

Location

ALEXANDRIA, VA

18. Funeral director

V. S. EVERLY

Address

ALEXANDRIA VA

JAN 29 1946
(Date rec'd by registrar)

James Severs
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 19 46 at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 19 46 to Jan 29 19 46
and that I last saw him alive on Jan 28 19 46

Immediate cause of death

Arteriosclerotic heart disease

DURATION

2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James Severs MD

M. D. or other

Address

322 H St NE

Date signed

1-29-46

RECEIVED
FEB 1 1946
BUREAU VER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (332)

CERTIFICATE OF DEATH

01079

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's

City or town Capital Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30

Hospital, institution, or street address where death occurred:

6318 - Brooks Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo.

City or town Capital Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6318 - Brooks Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

David Simms

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Nelson Dugga Simms

7. Birth date of deceased (mo., day, yr.)

Sept. 1872

6. (c) If alive, give age 60 years

8. AGE:

74 Years - Months - Days - hrs. - min.

9. Birthplace

Prince Georges Co. Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farming

MOTHER

FATHER

12. Name

Patrick Simms

13. Birthplace

Pr. Geo. Co. Md.

14. Maiden name

Catherine Simms

15. Birthplace

Pr. Geo. Co. Md.

16. Informant

Nelson Dugga Simms

Address

6318 - Brooks Rd.

17. (Burial, cremation, or removal. Which?)

Removal

Date thereof 1-8-46
(month) (day) (year)

Cemetery or crematory

Springfield, W.C.

18. Funeral director

John J. Stewart

Address

307 N. 1st St.

19. 1-8

1946

Carrie F. Campbell

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 19 46 at 5:40 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 12 19 45 to Jan 8 19 46

and that I last saw him alive on Jan 8 19 46

Immediate cause of death

Hypertension

Coronary

Haemorrhage

Due to

Due to

Other conditions Acute Arthritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

H. B. Beal

M. D. or other

Address 4623 - Hunt Pl. Date signed 1-8-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58-
16
74

1929
16

RECEIVED
MAR 18 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (123)

00841

FILM No. I 00 JAN 18 1946

CERTIFICATE OF DEATH

★ Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George
City or town Chesley Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:

Prince George General

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Prince George

City or town Beltsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Kennedy Simms

3.(b) Social Security Number

4. Sex

m

5. Color or race

w

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Jennie Simms

8.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Dec. 15, 1875

8. AGE:

Years

Months

Days

It less than one day

70

49

hrs.

min.

9. Birthplace

md.

(Town, county, and state)

10. Usual occupation

groceries

11. Industry or business

FATHER

MOTHER

12. Name

Alexander Simms

13. Birthplace

Ireland

14. Maiden name

Margaret Nichols

15. Birthplace

md.

16. Informant

Address

Mrs. Jennie Simms

Beltsville Md.:-

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 5, 1946
(month) (day) (year)

Cemetery or crematory

St. John's Cemetery

Location

Beltsville Md.

18. Funeral director

Address

F. Gascia song

Beltsville Md.

19.

(Date rec'd by registrar)

19.

46

Amanda Doney

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3 1946 at 11²⁵ P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct 31 1945 to Jan 3 1946

and that I last saw him alive on Jan 3 1946

Immediate cause of death

Toxemia

Due to

fecal fistula

Due to

Other conditions

abdominal wall

abscess

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

John M. Gorman

M. D. or other

Address

Prince Geo Esch

Date signed

1-4-46

RECEIVED

RECEIVED

JAN 9 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-9

CERTIFICATE OF DEATH

Reg. Dist. No.

01078

242

1. PLACE OF DEATH:

County Prince GeorgesCity or town Washington 19 DC
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County pr geor coCity or town Ritchie
(If outside city or town limits, write RURAL and give nearest town)Street No. 6501-Ritchie Road SE
(If rural, give LOCATION)2.(a) If veteran, name war us 19 DC

3. (a) FULL NAME

Hosinger Smith

3. (b) Social Security Number

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Alberta B. Smith7. Birth date of deceased (mo., day, yr.) Dec 23 18838. AGE: Years 62 Months Days If less than one day
hrs. min.9. Birthplace pa
(Town, county, and state)10. Usual occupation farmer

11. Industry or business

12. Name Ellsworth L. Smith13. Birthplace pa14. Maiden name Emilie Hassinger15. Birthplace pa16. Informant ms alberta B. SmithAddress 6501-Ritchie Road Wash 19 DC17. Burial, cremation, or removal. Which? Burial Date thereof Jan 23-1946
(month) (day) (year)Cemetery or crematory Eden Hill CemeteryLocation Smith and Maryland18. Funeral director Thomas F. MurrayAddress 2007-Nichols Ave SE, Wash DC19. 1-20 19 46 Thos D. Giffitt
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 19 46 at 7:30 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 19 46 to Jan 20 19 46 and that I last saw him alive on Jan 19 19 46Immediate cause of death Cerebral hemorrhage
Paralytic of left side of bodyDue to General Arterio-
Sclerosis

Due to

Other conditions none of note

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: noneAccident, suicide, or homicide none Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury none Injured at work?23. SIGNATURE Paul O. H. Smith M. D. or otherAddress Washington 19 DC Date signed Jan 20 19 46

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF JAILER

20. SIGNATURE OF WARDEN

21. SIGNATURE OF CHIEF OF POLICE

22. SIGNATURE OF DEPUTY CHIEF OF POLICE

23. SIGNATURE OF SHERIFF

24. SIGNATURE OF DEPUTY SHERIFF

25. SIGNATURE OF JAILER

26. SIGNATURE OF WARDEN

27. SIGNATURE OF CHIEF OF POLICE

28. SIGNATURE OF DEPUTY CHIEF OF POLICE

29. SIGNATURE OF SHERIFF

30. SIGNATURE OF DEPUTY SHERIFF

31. SIGNATURE OF JAILER

32. SIGNATURE OF WARDEN

33. SIGNATURE OF CHIEF OF POLICE

34. SIGNATURE OF DEPUTY CHIEF OF POLICE

35. SIGNATURE OF SHERIFF

36. SIGNATURE OF DEPUTY SHERIFF

37. SIGNATURE OF JAILER

38. SIGNATURE OF WARDEN

39. SIGNATURE OF CHIEF OF POLICE

40. SIGNATURE OF DEPUTY CHIEF OF POLICE

41. SIGNATURE OF SHERIFF

42. SIGNATURE OF DEPUTY SHERIFF

43. SIGNATURE OF JAILER

44. SIGNATURE OF WARDEN

RECORDED
MAR 18 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 730

CERTIFICATE OF DEATH

Reg. Dist. No. 00842
245

I. PLACE OF DEATH:

County Prince Georges
City or town Hyattsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Sacred Heart Home
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Hyattsville Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. _____
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Marie A. Soper

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Joseph A. Soper

7. Birth date of deceased (mo., day, yr.) April 23, 1848

8. AGE: Years 97 Months _____ Days _____ If less than one day _____ hrs. _____ min. _____

9. Birthplace Esnaabriick Germany
(Town, county, and state)

10. Usual occupation none

11. Industry or business _____

12. Name unknown

13. Birthplace _____

14. Maiden name unknown

15. Birthplace _____

16. Informant Miss Charlotte M. Ellerbrock

Address 2001-16 St NW Wash. D.C.

17. Burial Date thereof January 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fondan Park Cemetery

Location Baltimore Md

18. Funeral director Frank Leiers Sons Co

Address 3605-14 St NW Wash. D.C.

19. Jan 11 46 James Seery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 19 46, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 43, to Jan 11 19 46, and that I last saw her alive on Jan 11 19 46.

Immediate cause of death Congestive failure
Arteriosclerotic Heart Disease DURATION 1 week
Basal

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings:

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____

Injured at work? _____

23. SIGNATURE Thomas Hallins

M. D. or other

Address 322- H Street NE Date signed 1-11-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

324 H 22

RECEIVED

JAN 14 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00843 2415

1. PLACE OF DEATH

County Pr. Geo. Co.City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Pr. Geo. Co.City or town 2-9 West Way Rd
(If outside city or town limits, write RURAL and give nearest town)Street No. Greenbelt
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William T. Therrell

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Lula A. Therrell7. Birth date of deceased (mo., day, yr.) Feb-3-18608. AGE: Years 85 Months Days If less than one day
hrs. min.9. Birthplace Miss
(Town, county, and state)10. Usual occupation Merchant

11. Industry or business

12. Name Wm T. Therrell13. Birthplace Miss14. Maiden name Lula Scott15. Birthplace Miss16. Informant Wm TherrellAddress 2-9 West Way Rd.17. By train Date thereof 1-10-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Eupora CemeteryLocation Eupora, Miss18. Funeral director Wm. Chunks &Address Greenbelt19. Jan. 10, 1946 James Stevens
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9-46 at 3 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1, 1945 to Jan 9, 1946 and that I last saw him Jan 9 alive on Jan 9 1946Immediate cause of death failure DURATIONDue to Pneumonia 7-8 days

Due to

Other conditions Carcinoma face 21 years

(Include pregnancy within months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William K. Eisner M.D.
M. D. or otherAddress 30 B. Ridge Rd. Date signed 1-9-46
Greenbelt, Md.

INVESTIGATION OF DEATH

NAME OF DECEASED

STATEMENT OF WITNESSES

RECEIVED
JAN 14 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18th)

CERTIFICATE OF DEATH

00844

245

Reg. Dist. No.

1. PLACE OF DEATH:

County... Prince Georges

City or town... Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Prince George

City or town... Riverdale
(If outside city or town limits, write RURAL and give nearest town)Street No... Goodluck Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Shelton William Thomas

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Oct. 20, 1945

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

3

8

hrs.

min.

9. Birthplace... Riverdale Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name...

George H. Thomas

13. Birthplace

Washington, D.C.

14. Maiden name...

Vina Rice

15. Birthplace

Charlottesville, Va.

16. Informant... Mr. George H. Thomas (father)

Address

Goodluck Rd. Riverdale, Md.

17. (Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory...

Fort Lincoln

Location...

Colmar Manor Md.

18. Funeral director...

F. Gasch's sons

Address

Hyattsville Md.

19. Date rec'd by registrar

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Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 28, 1946, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death...

Asphyxia

DURATION

Due to... Asphyxia in bed

Due to... Clothing

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Accident Date of 1-28-46

Where did injury occur? Riverdale P.G. Co. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury... Asphyxia in bed

Reported medical examiner... Deputy Medical Examiner

23. SIGNATURE... James J. J. (Signature)

M.D. or other

Address... Forestville Md. Date signed 1-28-46

STAMP ON FRONT OF THIS CARD

RECEIVED

RECEIVED
FEB 1 1946
BUREAU V.S.

Handwritten notes, possibly "Bureau V.S."

Handwritten notes at bottom left, including "Bureau V.S."

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:

County pr. Geo To
City or town FRIENDLY Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County pr. Geo To
City or town FRIENDLY Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 8445-ALLENTOWN Road
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME

James Dennis Thorne

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife MARY T. THORNE

6. (c) if alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 22 - 1862

8. AGE: Years 83 Months Days If less than one day hrs. min.

8. Birthplace FRIENDLY Md
(Town, county, and state)

10. Usual occupation RETIRED FARMER.

11. Industry or business

12. Name WASHINGTON THORNE

13. Birthplace Md

14. Maiden name REBURTA BAUM

15. Birthplace Md

16. Informant Mrs Ruby E. Thorne

Address 8445 Alletown Rd Wash 20

17. Burial Date thereof Jan 8 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Providence M. E. Church

Location Friendly Md

18. Funeral director Thomas F. Murray

Address 2007- Nichols Ave SE.

19. Jan 8, 1946 Signed J. Beall
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1946 AM 10:00

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 to Jan 6 1946

and that I last saw him alive on Dec 28 1945

Immediate cause of death Congestive Heart Failure 1 mo.

Due to myocardial infarction 256

Due to arteriosclerosis 10 yr.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. W. Schwartz MD

Address 1225 Talbot HKE M. D. or other

Date signed 1/6/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

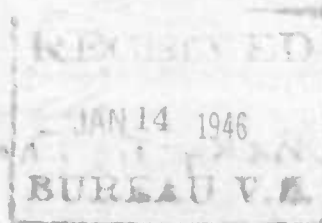
PHYSICIAN

Please underline the cause to which death should be charged statistically.

5-24

8442-2448-2448
MAR 14 1946
F. B. I.

DM



DM

RECEIVED
JAN 14 1946
BUREAU V. A.

RECEIVED
JAN 14 1946
BUREAU V. A.

RECEIVED
JAN 14 1946
BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

00846

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 mos., 11 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 3 mos., 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1510 Howard Rd. S. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3.(a) FULL NAME

ORA UPSHAW

3.(b) Social Security Number

-

4. Sex

F

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

-

7. Birth date of deceased (mo., day, yr.)

February 6, 1907

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

38

11

2

hrs.

min.

9. Birthplace Caroline County, Virginia
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

FATHER

12. Name

Joseph Upshaw

13. Birthplace

Virginia

MOTHER

14. Maiden name

Ida Pearl Upshaw

15. Birthplace

Virginia

16. Informant Decedent

Address

Removal

17. (Burial, cremation, or removal. Which?)

Date thereof Jan 10, 1946
(month) (day) (year)

Cemetery or crematory

to Washington, D.C.

Location

18. Funeral director

Ambrose B. Boyd

Address

1238-20th St N. W.

19. Jan 10, 46 (Date rec'd by registrar)

Rowland S. Phillips
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 19 46, at 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 28 19 45 to Jan 8 19 46and that I last saw him/her alive on Jan 8 19 46Immediate cause of death Brain Abscess

DURATION

4 daysDue to Lung Abscess6 mos.Due to Pulmonary tuberculosis5 mos.

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Brain abscess

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Daniel Leo Pinucane MD
M. D. or otherAddress Glenn Dale, Md Date signed 1/10/46

RECEIVED
JAN 16 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH: County..... <u>Prince George</u> City or town..... <u>Frederick</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred: <u>Island Memo</u> How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>MD</u> County..... <u>Washington</u> City or town..... <u>Washington</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>1119 - 47 St SW</u> (If rural, give LOCATION) 2.(a) If veteran, name war..... <input checked="" type="checkbox"/>			
3. (a) FULL NAME <u>FANNIE WEDGE WEGE</u>				3. (b) Social Security Number			
4. Sex <u>M</u>				5. Color or race <u>Sh. I married</u>			
6. (b) Name of husband or wife <u>John L. Wedge</u>				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>Aug 12/41</u>				8. AGE: Years <u>44</u> Months..... Days..... If less than one day..... hrs..... min.			
9. Birthplace <u>Rossmore Va</u> (Town, county, and state)				10. Usual occupation			
11. Industry or business				12. Name <u>know</u>			
13. Birthplace <u>Va</u>				14. Maiden name			
15. Birthplace <u>Va</u>				16. Informant <u>John L. Wedge</u> Address..... <u>1119 - 47 St SW</u>			
17. (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof..... <u>1/15/46</u> (month) (day) (year) Cemetery or crematory..... <u>Washington Hill</u> Location..... <u>Washington DC</u>				18. Funeral director <u>Sh. H. Humphreys Co</u> Address..... <u>317 - 19 St SW</u>			
19. (Date rec'd by registrar) <u>Jan 15</u> <u>46</u>				20. DATE OF DEATH <u>Jan 15</u> 19 <u>46</u> at <u>5:00 P</u> M			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Jan 8</u> 19 <u>46</u> to <u>Jan 14</u> 19 <u>46</u> and that I last saw him alive on <u>Jan 14</u> 19 <u>46</u> Immediate cause of death..... <u>myocardial infarction</u> Due to..... <u>Hypertension, cardiac disease, unknown</u> Due to..... <u>Diabetes</u> Other conditions..... (Include pregnancy within 3 months of death)							
Major findings of operations Date of op..... Antopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....							
23. SIGNATURE <u>Henry J. Zedler</u> M. D. or other..... Address..... <u>1250 Capital</u> Date signed.....							

Registrar

RECEIVED

JAN 18 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age
is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51)

FILM No. I O O FEB 5 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges County

City or town Cheverly Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 1365 E St. S.E. D.C.

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Weismiller, Mrs. Mary

3. (b) Social Security Number

4. Sex 7 5. Color or race W 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 17 - 1890

8. AGE: Years 65 Months 66 Days It less than one day hrs. min.

9. Birthplace Austria (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name unknown Harant

13. Birthplace Austria

14. Maiden name unknown

15. Birthplace Austria

16. Informant Mr. Frank Weismiller

Address 2404 Greene Chapel Rd. Laurel Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/31/46 (month) (day) (year)

Cemetery or crematory St. Luke's

Location

18. Funeral director W. W. Chambers &

Address 517 - 11th St. S.E.

19. 1/28 46 Amanda Doney

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 1-28-46 at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Chronic degenerative nephritis

Due to unknown

Due to

Other conditions Hepatic Degeneration

Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Allen S. Cross M.D.

M. D. or other

Address Date signed

CERTIFICATE OF DEATH

RECEIVED
JAN 30 1946
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00849

Reg. Dist. No. 239

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:

County Frederick

City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

128 West 13th St. Laurel

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pi Geo

City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No. 128 West 13th St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Emma M. Whitehead

3. (b) Social Security Number

4. Sex F. 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Thomas O. Whitehead

7. Birth date of deceased (mo., day, yr.) Sept-10-1866 6.(c) If alive, give age 79 years

8. AGE: Years 79 Months 3 Days 25 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Other Health

13. Birthplace Maryland

14. Maiden name Naomi Whitehead

15. Birthplace Maryland

16. Informant Mrs Sarah Clam

Address Laurel Maryland

17. Burial, cremation, or removal. Which? Burial Date thereof Jan-7-46
(month) (day) (year)

Cemetery or crematory Spring Hill

Location Laurel Md

19. Funeral director Paul Kauer

Address Laurel Md

19. January 7 46 Car E. Wadette Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1946 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 28 1937 to Jan 4 1946 and that I last saw her alive on Jan 4 1946

Immediate cause of death Myocarditis

Arteriosclerosis

Due to Intestinal Flu

Due to Influenza

Other conditions Cataracts

(Include pregnancy within 3 months of death)

DURATION

5 yrs

10 days

10 days

10 yrs

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury injured at work?

23. SIGNATURE J. M. Warren M.D.

M. D. or other

Address Laurel Date signed 1/7/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 14 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137a

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince GeorgeCity or town Suitland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George W. Wilson

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 15, 1866

B. (c) If alive, give age _____ years

8. AGE: Years 79 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Washington D.C.
(Town, county, and state)10. Usual occupation Retired11. Industry or business Navy Yard Wash. D.C.12. Name Charles H. Wilson13. Birthplace Washington, D.C.14. Maiden name Margaret Ann Scott15. Birthplace Wash. D.C.16. Informant Charles H. Wilson Jr.Address 4711 Suitland Rd Suitland17. Burial Date thereof 1-28-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar HillLocation Suitland Md.18. Funeral director W. W. Chambers CoAddress 517 11th St S.E.19. 1-26 19 46 Carrie F. Campbell
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince GeorgeCity or town Suitland
(If outside city or town limits, write RURAL and give nearest town)Street No. 5028 Suitland Road

(If rural, give LOCATION)

2. (a) If veteran, name war No

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25, 1946 at 7:30 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19, 1940 to Jan 25, 1946and that I last saw him alive on Jan 24, 1946Immediate cause of death acute cardiac failureDue to cardiovascular renal disease and chronic bronchial asthma

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: noAccident, suicide, or homicide no Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul E. Smith M. D. or other _____Address Washington D.C. Date signed Jan 25, 1946

RECEIVED

APR 25 1946

BUREAU V.S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01083

1. PLACE OF DEATH

County Prince GeorgesRegistration Dist. No. 242Village or City Seat PleasantNo. 5961 Rollins Ave. St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.2. FULL NAME Lillie Adeline Wilson If U. S. Veteran, specify WAR (a) Residence: No. 5961 Rollins Ave. Seat Pleasant Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Joseph Herblin Wilson</u>		
6. DATE OF BIRTH (month, day, and year) <u>May 31, 1880</u>		
7. AGE <u>65</u>	Years <u>7</u>	Months <u>3</u>
		Days <u>3</u>
		If LESS than 1 day, <u> </u> hrs. or <u> </u> min.
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Housewife</u>		
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>Home</u>		
10. Date deceased last worked at this occupation (month and year) <u>Aug 1941</u>		
11. Total time (years) spent in this occupation <u> </u>		

12. BIRTHPLACE (city or town) Axon Hill Md.
(State or country)13. NAME John Nightingill
14. BIRTHPLACE (city or town) Alexandria Va.
(State or country)15. MAIDEN NAME Clara Lathimer
16. BIRTHPLACE (city or town) Axon Hill Md.
(State or country)17. INFORMANT Mrs. Joseph H. Wilson
(Address) 5961 Rollins Ave. Seat Pleasant, Md.18. (BURIAL) CREMATION, OR REMOVAL
Place Addison Chapel Date Jan 7th, 194619. UNDERTAKER Wm. J. Haller
(Address) 3200 St. Albans Dr. Gaithersburg, Md.20. FILED Jan 6, 1946 John Sevey
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

January, 1946
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from

April 15, 1944, to January 4, 1946.I last saw him alive on January 4, 1946, death is saidto have occurred on the date stated above, at 9:25 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Pulmonary Tuberculosis

Date onset

April 1944

Other Contributory Causes of Importance:

Diabetes MellitusApril 1944Name of operation Date of What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury , 19 Where did Injury occur?

(Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury Nature of Injury

24. Was disease or Injury in any way related to occupation of deceased?

If so, specify

(Signed) William Brannin M. D.(Address) 6124 Central Ave. Capitol Heights, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis

Date of onset

1915

Chronic interstitial nephritis

1921

Cerebral hemorrhage

July 5, 1927

Other contributory causes of importance:

Gallstones

May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy

Date of onset

1 week ago

Run over by street car

1 week ago

Peritonitis

3 days ago

Other contributory causes of importance:

Gastroenteritis

1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

Reg. Dist. No. 243

00850

1. PLACE OF DEATH:

County... Prince George's
 City or town... (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 mos., 10 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution? 4 mos., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D. C. County...
 City or town... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 1850 Ontario Pl. N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... - ✓

3. (a) FULL NAME

PAULINE WILSON

3. (b) Social Security Number

None

4. Sex... Female
 5. Color or race... White
 6.(a) Single, married, widowed, or divorced... Married.
 6.(b) Name of husband or wife... Jas. B. Wilson.
 6.(c) If alive, give age... 31 years
 7. Birth date of deceased (mo., day, yr.)... May 25, 1916
 8. AGE: Years 29 Months 7 Days 16 It less than one day
 hrs. min.

9. Birthplace... Warsaw, Poland
 (Town, county, and state)
 10. Usual occupation... Housewife
 11. Industry or business
 12. Name... Samuel Weisman
 13. Birthplace... Warsaw, Poland
 14. Maiden name... Lillian Shapiro
 15. Birthplace... Warsaw, Poland
 16. Informant... Decedent

Address
 17. Removal... Date thereof... Jan. 11, 1946.
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory...
 Location... to Washington, D. C.
 18. Funeral director... Deal Funeral Home
 Address... 4812- Garver N.W. Washington, D.C.
 19. Jan. 10, 1946 Rowlands Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan 10th 1946 at 5⁵⁰ P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 31st 1945 to Jan 10th 1946 and that I last saw her alive on Jan 10th 1946.
 Immediate cause of death...

Pulmonary Tuberculosis
 Due to...
 Due to...
 Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations... Date of op...
 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... Daniel Leo Pinecone
 Address... Glenn Dale, Md. Date signed... 1/10/46

RECEIVED
JAN 16 1944
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The current age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Geo's County
 City or town Cheverly, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince Geo's Gen. Hospital

How long in hospital or institution?

1 mth. 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince Geo's County
 City or town Mt Rainier, Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 4606-30th St. Mt Rainier, Md.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Wittner, Mr. Albert.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

Mrs. Ann Wittner

7. Birth date of deceased (mo., day, yr.)

Aug 8 - 19046.(c) If alive, give age 32 years

8. AGE:

Years

41

Months

5

Days

26

If less than one day

.....hrs.min.

9. Birthplace

New York City, N.Y.
(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

Construction

FATHER

12. Name

Charles Wittner

13. Birthplace

Roumania

MOTHER

14. Maiden name

Rebecca Ochs

15. Birthplace

Roumania

16. Informant

Mrs. Ann Wittner

Address

4606 - 30th St. Mt. Rainier Md17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

1-28-46
(month) (day) (year)

Cemetery or crematory

Washington All

Location

B Danzansky & Son

18. Funeral director

Address

3501-14th St NW19. 1/28

(Date rec'd by registrar)

19. He Annette Dewey

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 26.19. 46 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....
 and that I last saw h.....alive on.....19.....

Immediate cause of death

Myocardial infarction

DURATION

Due to

Arterio-sclerosis

Due to

Other conditions

Dehydr. mellitus

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James Schwaib

M. D. or other

Address

Prince Henry Hospital

Date signed

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE CITY OF BOSTON

FILE NO. 100-100000

RECEIVED

JAN 30 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (312)

CERTIFICATE OF DEATH

Reg. Dist. No. 00852
245

1. PLACE OF DEATH:

County Prince George's
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hour
Hospital, institution, or street address where death occurred:
5223 - 42nd Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5118 Decatur Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Fredrick Xander

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Mary Xander
7. Birth date of deceased (mo., day, yr.) Nov 14, 1875 8.(c) If alive, give age _____ years
8. AGE: Years 70 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace German
(Town, county, and state)
10. Usual occupation Gardener
11. Industry or business _____
12. Name unknown
13. Birthplace Germany
14. Maiden name unknown
15. Birthplace Germany

16. Informant Mrs Lena Dobson
Address P.F.D#1, Falls Church, Va
17. Burial Date thereof Feb 4, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Prospect Hill
Location Washington D.C.
18. Funeral director L. Pasche some
Address Hyattsville Md.
19. Feb 4 1946 James Sever
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1946 at 7:00 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____
and that I last saw him _____ alive on _____ 19____
Immediate cause of death acute congestive heart failure
Due to cardiovascular renal disease
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE James D. [Signature] M. D. of other _____
Address Forestville Md. Date signed 2-3-46

RECEIVED

U.S. DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D.C.

RECEIVED

FEB 6 1946

U.S. DEPARTMENT OF JUSTICE